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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 be updated from time to time 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

Appeal types

There are two types of internal Member appeals:

- **Medical Necessity appeals:** Medical Necessity appeals relate to denials based on Medical Necessity, medical appropriateness, clinical issues, experimental or investigational exclusions, or cosmetic exclusions. There is one internal level for a Medical Necessity appeal.
- **Appeal of an Administrative Denial:** This type of appeal relates to denials or disputes regarding coverage, including contract exclusions, noncovered services, participating or nonparticipating health care Providers, certain surprise medical bills received by a Member from an out-of-network provider, rescissions of coverage (except for non-payment of premiums or coverage contributions), or other contractual terms of the health plan. There are two internal levels for an Appeal of an Administrative Denial.

Appeal classifications

- **Pre-Service Appeal:** An appeal of an adverse determination for coverage of care or services, which must be pre-approved by the Plan in advance of the Member obtaining care or services.
- **Post-Service Appeal:** An adverse determination for coverage of care or services that have been received by the Member and/or services where the Plan does not require prior authorization in advance of the care or service being rendered.

Pennsylvania fully insured lines of business are subject to federal and Pennsylvania regulatory requirements, as well as the National Committee for Quality Assurance (NCQA) guidelines. Member Appeals procedures are subject to change.

Upon completion of the internal Member appeals process, the Member or the authorized representative may request an external appeal via the Pennsylvania Insurance Department's Bureau of Health Coverage Access, Administration and Appeals (HCA3). Please refer to the External Review section of this document.

Medical Necessity appeals (clinical issues)

There is one level for an internal standard Medical Necessity appeal. A Plan Medical Director (MDR) who holds an active unrestricted license to practice medicine is the decision maker. Additionally, this individual has no previous involvement with the case and is not a subordinate of anyone previously involved. Either the Plan MDR or an independent physician consultant is in the same/similar specialty as the physician managing the Member's care. The decision is made for both a pre-service or post-service appeal and the notification is sent to the Member or authorized representative within thirty (30) calendar days of the Member's or authorized representative's receipt of the adverse benefit determination letter. For non-formulary

exception requests, the decision is made, and notification is sent within seventy-two (72) hours of the Plan's receipt of the request.

There is one level of internal expedited Medical Necessity appeal. 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. The Plan's decision process for an expedited appeal mirrors the process for the standard appeal described above. The decision for an expedited appeal is made and notification sent to the Member or authorized representative within seventy-two (72) hours of the Plan's receipt of the request. For non-formulary exception requests, the decision is made, and notification sent within twenty-four (24) hours of the Plan's receipt of the request.

Appeal of an Administrative Denial

There are two internal levels of an Appeal of an Administrative Denial. For each level of appeal, the decisions are made, and notification is sent to the Member or authorized representative within fifteen (15) calendar days of the Plan's receipt of a pre-service appeal request and within thirty (30) calendar days of receipt of a post-service request.

The decision maker for the internal Level I appeal is a Plan employee familiar with managed care and benefits. This individual has no prior involvement with the case and is not the subordinate of anyone previously involved. For an internal Level II appeal, the decision is made by a three-person committee consisting of two Plan employees and a non-employee voter who have no previous involvement in the case and who are not the subordinate of anyone previously involved in the case.

If the Member or the authorized representative remains dissatisfied with the Plan's decision, the Member or authorized representative may contact the Pennsylvania Insurance Department (PID) for an external review at the following contact information:

Pennsylvania Insurance Department
Bureau of Health Coverage Access,
Administration and Appeals (HCA3)
1311 Strawberry Square
Harrisburg, PA 17120
Toll Free:1-888-466-2787
Fax: 717-231-7960
Email: *RA-IN-ExternalReview@pa.gov*
Online: *insurance.pa.gov/externalreview*

Pennsylvania Insurance Department
Bureau of Consumer Services
1209 Strawberry Square
Harrisburg, PA 17120
Toll Free: 1-877-881-6388
Fax: 717-787-8585

External Independent Review Organization (IRO) process

The External Review process is applicable for decisions based on Medical Necessity, experimental/investigational treatment, cosmetic issues, certain surprise medical bills received by the Member from out-of-network providers, and rescissions of coverage (except for non-payment of premiums or coverage contributions). The Member or authorized representative does not bear any of the costs associated with the External Review.

Please refer to the final internal appeal adverse benefit determination letter for specific instructions on how to file an appeal with the HCA3.

The Member or authorized representative may file a written request for a standard external appeal with the HCA3 within four (4) months of their receipt of the Plan's adverse benefit determination or final adverse benefit determination. Expedited requests may also be filed verbally. The HCA3 contracts directly with the IRO and notifies the Plan, Member, or authorized representative of the assignment for each case file.

A Member or authorized representative may only request an external review after exhausting the internal appeal process. The Member or authorized representative shall be deemed to have exhausted the internal appeal process in the following circumstances:

- The Member or authorized representative has filed a Medical Necessity Appeal.
- Except to the extent the Member or their authorized representative has requested or agreed to a delay, the Plan has not issued a decision to the Member or authorized representative within thirty (30) calendar days of when the Member or authorized representative filed the appeal with the Plan.
- The Plan waives its requirement that the Member or authorized representative must exhaust the internal claim and appeal process prior to filing a request for an external review or expedited external review.
- The Plan has failed to comply with the requirements of the internal claims, utilization review and/or appeals process unless the failure or failures are based on de minimis violations that are not likely to cause prejudice or harm to the Member or authorized representative.

Standard External Review IRO decision

The assigned IRO decides the appeal and sends notification to the Member or authorized representative within forty-five (45) calendar days of receipt of the external review request. For an external review of experimental/investigational treatment, the assigned IRO decides and sends notification to the Member or authorized representative within twenty (20) calendar days of receipt of the external review of the experimental/investigational treatment request.

Upon receipt of an IRO overturn decision, the Plan will approve the request that was the subject of the external review within twenty-four (24) hours.

All IRO decisions are binding on the Plan.

A Member or authorized representative may request an expedited external review at the same time as the internal expedited appeal process in the following circumstances:

- The Member has an urgent care condition for which the timeframe for completion of an expedited internal review of the adverse benefit determination would seriously jeopardize the life or health of the Member or would jeopardize the Member’s ability to regain maximum function.
- The final adverse benefit determination concerns an admission, availability of care, continued stay, or health care service for which a Member receives emergency care but has not been discharged from a facility.
- The final adverse benefit determination involves a determination that the recommended or requested health care service is experimental or investigational, and the Member’s treating health care provider certifies in writing that the recommended or requested health care service that is the subject of the adverse benefit determination would be significantly less effective if not promptly initiated.

Expedited External Review IRO decision

Within seventy-two (72) hours of receipt of the request, the IRO makes their decision and notifies the Member or authorized representative, the HCA3, and the Plan.

Upon receipt of an IRO overturn decision, the Plan will approve the request that was the subject of the external review within twenty-four (24) hours.

All IRO decisions are binding on the Plan.

Self-insured groups

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

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 an Administrative Denial. 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, IBX mails the Member a consent form for a Provider to file an appeal on their behalf. The *Member Consent for Provider to File an Appeal on my Behalf with Health Insurance Plan* form is also available online at *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 initial 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.

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^{SM} 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 their 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
ibxmedicare.com

For all Part D standard appeals, the Member or their 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
ibxmedicare.com

For all Part C and Part D *expedited* appeals, the Member or their 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
ibxmedicare.com

For all Part C Medicare Advantage appeals, if the original denial is upheld after the review by IBX, 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 IBX, the Member of their 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 IBX 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, IBX 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 IBX 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 their 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, their 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 their 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, their 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

IBX offers a two-level post-service billing dispute process for professional Providers. For services provided to any IBX 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 IBX 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.

IBX 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, they 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 IBX.

Provider grievance process

IBX offers a one-level post-service grievance process for professional Providers. For services provided to any IBX 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

Emergency room (ER) claims that do not meet IBX'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 *ibx.com/providerforms*), attach the Member's medical record, and submit to submit to:

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