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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 appeals on behalf of Members — Medical Necessity and Administrative.

- **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 statutes, or other contractual terms of the health plan.

Appeals can be pre-service or post-service and may be processed within 48 hours for an expedited appeal or in a standard time frame. Standards for appeal time frames and processes are established by applicable State and federal laws, as well as national accrediting organization guidelines adopted by AmeriHealth. Appeal 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 plan 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 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 *Member Consent for Provider to File an Appeal on my Behalf with Health Insurance Plan* form is available at *www.amerihealth.com/providerforms*. 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, AmeriHealth 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.amerihealth.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.

HMO/POS Medical Necessity external reviews (grievances) – (i.e., Medical Necessity/clinical issues)

A Member, the Member's authorized representative, or the Provider on behalf of the Member, for a 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 a Certified Review Entity (CRE), an Independent Utilization Review Organization (IURO) approved by the Pennsylvania Department of Insurance's Bureau of Managed Care, by following the instructions described in the final internal appeal decision letter.

AmeriHealth is responsible for coordinating the external review. We will forward all of the information presented during the internal appeals processes to the assigned Independent Review Organization (IRO). 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 above.

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 the 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.

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 on the previous pages.

Provider billing dispute process

AmeriHealth offers a two-level post-service billing dispute process for professional Providers. For services provided to any AmeriHealth Pennsylvania Member, Providers may dispute those 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 AmeriHealth 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 name, identification number, claim number(s), and date(s) of service under dispute. AmeriHealth 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 AmeriHealth.

Provider grievance process

AmeriHealth offers a one-level post-service grievance process for professional Providers. For services provided to any AmeriHealth Pennsylvania 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 containing the IRO decision and detailed explanation will be sent to the Provider. 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 via the Provider Engagement, Analytics & Reporting (PEAR) portal.

ER services appeals

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

Claims Medical Review – Emergency Room Review
AmeriHealth 1901 Market Street
Philadelphia, PA 19103-1480