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Overview

This section includes information about the process for Member appeals and Provider billing dispute appeals.

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 relate to denials based on Medical Necessity, medical appropriateness, or clinical issues.
- **Administrative appeals.** Administrative appeals relate to denials or disputes regarding nonmedical Administrative issues, benefits limits, or other contractual terms of the health plan.

Appeals can be pre-service or post-service and may be processed within 72 hours for an expedited appeal or in a standard time frame. Standards for appeals time frames and processes are established by applicable State and federal laws, as well as national accrediting organization guidelines adopted by AmeriHealth. Appeals procedures are subject to change.

An expedited appeal involving urgent care may be obtained with validation from the Member's Physician 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.

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 AmeriHealth 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 provider authorized to act on behalf of a Member may appeal decisions related to either Medical Necessity/appropriateness or Administrative (nonmedical necessity) denials. In most cases, the Member's 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.

HMO/POS/PPO Medical Necessity/Administrative appeals

If a Member, the Member's authorized representative, or provider on behalf of the Member has exhausted the internal process for an expedited or standard Medical Necessity/Administrative appeal and continues to be dissatisfied with the decision, he or she may appeal as outlined in the decision letter.

Mediation services are offered by the Delaware Insurance Department by calling Consumer Service at 1-800-282-8611.

Network providers giving or providing health and/or Emergency medical services and/or health insurance coverage may decide to arbitrate through the Delaware Insurance Department for covered claims arising from the provision of Emergency Services and appeals from decisions from the AmeriHealth internal appeal review process if filed within 60 days following the receipt of the written adverse determination. This excludes health claims or appeals that involve issues of Medical Necessity and/or the appropriateness of services or those already pending before any court or other administrative agency.

Note: The procedures described on the previous pages may change due to changes in the applicable State and federal laws and regulations, as well as accreditation standards. Also, a decision at any stage 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 the benefits contract as constructed by the determinations made through the appeals process.

Provider billing dispute appeal process

AmeriHealth offers a two-level billing dispute appeal process for professional providers. For Medically Necessary services, provided on or after April 21, 2008, to Members enrolled in Delaware benefit plans, providers may appeal claim denials related to general coding and the administration of claim payment policy.

Some examples of billing disputes are:

- bundling logic (integral, incidental, mutually exclusive claim edits);
- modifier consideration and application;
- claims adjudication settlement not consistent with law or contract.

The provider billing dispute appeal process does not apply to:

- utilization management determinations (e.g., claims for services considered not Medically Necessary, experimental/investigational, cosmetic, dental rather than medical);
- precertification/authorization/Referral requirements;
- benefit/eligibility determinations (e.g., claims for noncovered services) audit and investigations performed by the Corporate and Financial Investigations department;
- fee schedule concerns.

Billing dispute appeal submission

To facilitate a first- or second-level billing dispute review, submit inquiries to:

Provider Billing Dispute Appeals
P.O. Box 7930
Philadelphia, PA 19101-7930

If a provider disputes the first-level provider billing dispute appeal determination, he or she may then submit a second-level provider billing dispute appeal by sending a written request within 60 days of receipt of the decision of the first-level provider billing dispute appeal. The appeal will be reviewed by an internal Provider Appeals Review Board (PARB) consisting of three members, including at least one medical director. 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.

For claim explanation, providers may also call Customer Service at 1-800-275-2583.

Note: This provider claim payment appeal process applies to both Medicare Advantage and commercial Members.

Discussion about utilization management decisions

Information on utilization management decisions can be found in the *Care Management and Coordination* 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.

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 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