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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 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 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. There is only one level of internal review for an expedited appeal.

Self-insured information

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 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 Medical Necessity appeals (grievances) – (i.e., Medical Necessity/clinical issues)

A Member, the Member's authorized representative, or the provider on behalf of the Member, who has exhausted the internal 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 Department of Health, by following the instructions described in the level II decision letter.

The Clinical Services Liaison Unit is responsible for coordinating the external request. It will forward all of the information presented during the level I and level II appeals processes to the CRE. The Member, the Member's authorized representative, or the provider on behalf of the Member may submit additional information to the Clinical Services Liaison Unit within a specified time frame for submission to the external review entity at the address listed on *page 15.2*.

The CRE will review the information and issue a decision. For a standard level III review, the Member, the Member's authorized representative, or the provider on behalf of the Member is notified of the determination within 48 hours of an expedited request and within 60 days of the standard request.

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 appeal to the Pennsylvania Department of Health or Pennsylvania Insurance Department, as outlined in the level II decision letter.

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 Pennsylvania 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. Plan information is located on the Member's ID card.

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