Appeals & Reconsiderations

Operations

Policy Overview

Health Options is responsible for the oversight of all appeals and reconsiderations relating to adverse benefit and adverse health care treatment determinations that have been decided by Health Options as well as our delegated partners.

Appeals may be submitted by members, authorized representatives, or providers on behalf of members. To be considered, appeal requests must be filed within 180 calendar days of the adverse determination. The 180-day count commences with the date denoted on the applicable Authorization denial letter, Explanation of Benefits (EOB), or the Explanation of Payment (EOP) notice.

Claim reconsiderations may be submitted by providers on behalf of a member. Members are not notified when a provider submits a claim reconsideration. To be considered, claim reconsiderations must be filed within 90 calendar days of the adverse determination. The 90-day count commences with the date denoted in the applicable EOB, or the EOP notice.

Each appeal and reconsideration will receive prompt, thorough and impartial review. Health Options will, when warranted, reprocess claims and authorization requests as a result of a determination that are substantiated during the appeal review. All appeal and reconsideration related correspondence sent to members, representatives, and providers shall be written in layman's terms. Further guidance for members with special cultural needs or those requiring translation services are contained in the 'Appeal Rights and Information' document attached to all appeal and claim reconsideration correspondence to the members and providers. Also found on the website located at https://www.healthoptions.org/providers/resources/ under the guides tab.

Definitions

Adverse Benefit Determination: including but not limited to adverse health care treatment decisions: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including an action based on a determination of a participant's or beneficiary's ineligibility to participate in a plan.

Adverse Determination: a decision by a carrier to deny (in whole or in part), reduce, limit, or terminate health insurance benefits or claim.

Adverse Healthcare Treatment Decisions: denial decisions regarding diagnosis, care, or treatment when medical services are provided by a health plan, or a benefits decision involving determinations regarding medically necessary healthcare, preexisting condition determinations and determinations regarding experimental or investigational services.

Authorized Representative: a member-chosen person who the member has permitted (by way of an Appeal Representative Form) to act on their behalf in relation to the current appeal issue.

Board Certification: voluntary credential granted confirming a physician's advanced knowledge, training, and skills in a specialty or subspecialty.

Claim Reconsideration: Informal reconsideration request of a claim denial/ adverse determination that is submitted by a provider on behalf of the member.

Clinical Peer: a physician or other licensed health care practitioner who holds a non-restricted license in a state of the United States, is board certified in the same or similar specialty and typically manages the medical condition, procedure or treatment under review, and whose compensation does not depend, directly or indirectly, upon the quantity, type or cost of the medical condition, procedure or treatment that the physician or other licensed health care practitioner approves or denies on behalf of a carrier.

Member: any person who is eligible for services that are covered by the 'Member Benefit Agreement'. Member is inclusive of an Authorized Representative for the purpose of this policy.

Claim/ Non-UM (Utilization Management) Appeal: appeal of an adverse determination that is not related to Medical Management review (e.g., denied claim, eligibility determination, reinstatement, etc.) and is processed by the Health Options' claim appeals team with consult, if applicable, from other Health Options departments (e.g., Enrollment, Configuration, Data Integrity, etc.).

UM (Utilization Management) Appeal: appeal of adverse authorization determinations related to medical necessity, administrative policy (i.e., UM Submission Timeframes) or benefit design (i.e., benefit limits, non-covered services) that were rendered by Health Options' Medical Management team or applicable delegate.

Policy

Claim Reconsiderations, Level I and II Appeals

a. How to Submit

Claim reconsiderations and appeals are accepted by mail, fax, email or, in limited circumstances, by phone. Appeal requests may only be taken by phone when a verbatim statement is recorded by a Member Services Representative, or the Appeal Coordinator and it is promptly directed to the appeals team.

Forms located at https://www.healthoptions.org/providers/resources/ under the forms tab.
Email: reconsiderations@HealthOptions.org for reconsiderations
Email: appeals@healthoptions.org for appeals
Mail to:

Community Health Options, Reconsiderations and Appeals
Mail Stop 800
P.O. Box 1121
Lewiston, ME 04243-1121

Fax: (877) 314-5693
Phone: (207) 402-3755 for Expedited Appeals

Timelines:

- Claim reconsiderations: Within 90 calendar days of the adverse determination of the authorization denial or of the denial date of the EOP/EOB.
- Level I Appeals: Within 180 calendar days of the adverse determination of the authorization denial or of the denial date of the EOP/EOB.
- Level II Appeals: Within 180 calendar days of the level I appeal decision date.

If an appeal or reconsideration is not received timely, it will be dismissed.

b. Acknowledgement

Written acknowledgement must be sent withing 3 calendar days. 'Appeal Rights and Information' will be sent with each acknowledgement letter.

- Appeal acknowledgement letter will always be sent to the member and provider when the provider requests the appeal.
- Claim reconsiderations are only submitted by providers so the acknowledgement letters will be sent to the provider withing 3 calendar days.

c. Continuation of Coverage / Eligibility

Continued coverage applies to the denial, reduction, or termination of coverage for an ongoing course of treatment for which coverage was previously approved. Pending the outcome of an internal appeal of a concurrent care decision, the member shall receive continued coverage until the end of the approved treatment period or determination of the appeal (subject to regulatory and contractual obligations).

d. Review

Appeals and claims reconsiderations must be resolved and notice of the determination mailed to the member and/or provider within 30 calendar days of receipt of the appeal or claim reconsideration request. Prior to a determination, the member and/or his/her provider may continue to submit additional written comments, documentation, or other information in support of the appeal. All submissions will be added to the file and thoroughly considered when deciding on the request. The substance of appeals must be fully investigated including any aspects of clinical care involved, when applicable.

e. Level II Appeals Hearings (Optional)

For level II appeals, members, representatives, and/or providers have the right to request and attend a hearing on their level II appeal. If a hearing is requested, notice of the hearing must be provided at least 15 calendar days in advance of the hearing date, unless such notice is waived by the requestor. Level II appeals require a panel review. The panel will be established with individuals who were not involved in the initial denial, or level I appeal decision.

Administrative support staff and/or members of the appeal team may review and present the appeal but may not be involved in the decision. All appeal and reconsideration reviewers must not have been involved in the original decision or be a subordinate of the person(s) who made the original adverse determination. For appeals of adverse health care treatment decisions, the appeal reviewer must be a clinical peer, defined as being board certified in the same or

similar specialty and typically manages the medical condition, procedure, or treatment under review. The clinical peer may not have been involved in making the initial adverse health care treatment decision unless additional information not previously considered during the initial review is provided on appeal. If a Health Options employed clinical peer is unavailable or does not meet the required criteria, a third- party clinical peer may be used through an Independent Review Organization.

f. Determination

- Appeal resolution letter will be sent to the member, and when appropriate, the provider.
- Claim reconsiderations the letter is sent if the reconsideration is dismissed or denied but if it is overturned, one is not sent out.

The reprocessing of the claim along with the EOP notice is considered notification.

Notice of a level II appeal determination must be mailed to the member within 45 calendar days of the date of receipt of the appeal. If a level II hearing is waived, a determination must be mailed to the member and if applicable, the provider within 30 calendar days of the date of the receipt of the appeal. Health Options will not unreasonably deny a request for postponement of the review. The determination letter must be mailed to the member and/or provider when applicable, withing 5 calendars of the appeal decision for level II hearings.

External Review (UM Medical Necessity Appeals)

Members and providers may request an independent, external review of adverse medical necessity UM decisions. These include determinations regarding diagnosis, care, or treatment when medical services are provided by a Plan, or determinations regarding experimental or investigational services.

Requests for external review must be submitted within 12 months (365 calendar days) of the last adverse determination. Such requests should be sent to the state insurance department in which the member holds plan coverage. The address for the appropriate insurance department can be found in the Appeal Rights included with the acknowledgement letter and determination letters for the appeals.

Members and providers may not make a request for external review under a group plan until they have exhausted both their level I and level II Appeals Rights. Members of individual plans must exhaust their level I Appeal Rights prior to requesting external review. Members and providers may request an external review prior to exhausting their internal review options if:
1) Health Options fails to notify the member of a determination within the required time;
2) Health Options has not adhered to the procedures and requirements of this policy;
3) the member makes an expedited External Review request simultaneously with an expedited internal review;
4) Health Options and the member mutually agree;
5) the life or health of the member is in serious jeopardy;
6) the member is deceased; or

7) the adverse decision concerns an admission, availability of care, a continued stay or health care services after receipt of emergency services and the member has not been discharged.

Members and providers are never responsible for the cost of an external review.

Expedited Appeals
Expedited appeals are available to members and providers when the appeal involves a service that if delayed, could seriously jeopardize the health of the member or their ability to regain maximum function. The services eligible for this request are:
1) an inpatient admission;
2) availability of care barriers, or
3) continued health care or services for a member who has received emergency medical services and has not been discharged from the treating facility.

a. How to Submit
Expedited appeal requests should be submitted by phone to ensure prompt receipt. Calling the Appeals line at (207) 402-3755. The provider will be notified within 24 hours of receipt of the request, or on the first business day following after-hours or weekend requests. Health Options will notify the member's provider of all information required to thoroughly evaluate the appeal, if not received with the appeal request. If an expedited appeal is requested outside of normal business hours (Monday-Friday, 8:00AM- 5:00PM, except holidays), and the next business day is greater than 72 hours, appeals team members will have on-call coverage to ensure prompt processing of the appeal.

b. Review and Determination
Administrative support staff and/or members of the appeal team may review and present the appeal but may not be involved in decision. The person(s) deciding on an expedited appeal must not have been involved in the initial denial decision nor may they be a subordinate of the initial reviewer(s). If a Health Options employed clinical peer is unavailable or does not meet the required criteria, a 3rd party clinical peer will be used through an Independent Review Organization.

Determinations on expedited appeals will be made as expeditiously as possible, and within 72 hours after receipt of the request. Determinations will be delivered to the member and/or the provider by phone on the day of the decision. Written notification must be mailed within two (2) business days of the determination.

References / Resources

National Committee for Quality Assurance (NCQA). (2021, November 22). *Health Plan Accreditation (HPA), Section UM 8 Internal Appeals.* Retrieved from https://www.ncqa.org

National Committee for Quality Assurance (NCQA). (2021, November 22). *Health Plan Accreditation (HPA), Section UM 9 Timeliness of the Appeal Process.* Retrieved from https://www.ncqa.org

State of Maine Department of Professional and Financial Regulation. (2020, May 24). *Bureau of Insurance Chapter 850: Health Plan Accountability.* Retrieved from https://www.maine.gov/pfr/insurance/home

Related Policies

Medical Policy: Adverse Utilization Management Decisions

Document Publication History

09/23/2022 Initial publication

This policy provides information on Community Health Options' claims adjudication processing guidelines. As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization, and utilization management guidelines when applicable, adherence to plan policies and procedures, and claims editing logic. Community Health Options reserves the right to amend a payment policy at its discretion. Policies are enforced unless underpinning direction stated otherwise.