BlueCross BlueShield of Illinois

Policy Name: **Provider Standard Appeal Process**
Policy Number: **Utilization Management – 05**
Effective Date: **10/22/98**
Revision Date: **12/09/2022** **Review Date:** **02/23/2023**

Approval Signature

Vice President, Provider Performance

Line of Business

Commercial	Exchange	Government
☒ HMO	☒ HMO	☐ HMO
☒ PPO	☒ PPO	☐ PPO

Approving Body

☒ Policy and Procedure Committee Date: 02/23/2023

Details

Policy:

Blue Cross and Blue Shield of Illinois (BCBSIL) will review provider requests for standard clinical appeals resulting from an adverse determination in a thorough, appropriate and timely manner. Appeals will be reviewed by a clinical peer that was not involved in the original decision and not subordinate to the initial decision maker. The provider or facility may request an appeal either verbally or in writing.

Purpose:

A. To establish the process for handling provider standard appeal requests.
B. To ensure proper handling of provider standard appeals.
C. To ensure appeal review by a clinical peer as appropriate.

Guidelines:

A. A member, their authorized representative (including an attorney), physician, facility, or other health care provider may request an appeal on behalf of the member either verbally or in writing (the member can be represented by anyone they choose including an attorney). If a member selects an authorized representative to act on their behalf, written authorization from the member is required at the time of the request
B. BCBSIL may accept all the member and/or member's authorized representative (MAR) appeals regardless of the 180-day submission timeframe required by law
C. Upon request, members will be allowed to have continued coverage for ongoing services under their benefit plan pending the outcome of an internal appeal. This applies to

covered services only, BCBSIL will not reduce or terminate an ongoing course of treatment without providing advance notice and an opportunity for advance review

D. All relevant information received will be considered during the appeal process regardless of whether it was reviewed during the initial review.
E. All clinical appeals are reviewed by a board-certified clinical peer, in a same or similar specialty that typically manages the condition or care in question, who was not involved in the original decision and not a subordinate of the original decision-maker, nor will the reviewer give deference to the original decision.
F. Following receipt of an appeal, the designated appeal staff will review all information received and document the substance of the appeal and any actions taken including:
    1. The name of the covered person for whom the appeal is filed
    2. The member and/or member's authorized representative (MAR) reason for appealing the previous denial
    3. The date the appeal was received
    4. Additional clinical or other information provided with the appeal request
    5. Documentation of all previous relevant reviews and appeals including the reviewer and date of review
    6. Name and credentials of the clinical peer reviewer
    7. Resolution of each level of the appeal, if applicable
G. Language services are available to any BCBSIL member and/or member's authorized representative (MAR) including:
    1. Oral interpretation of documents that are written in English into a member's preferred language
    2. Member notification documents available in languages other than English
    3. Notices of the appeals process provided to members in a culturally and linguistically appropriate manner upon request
    4. Language-line interpretation services
H. The appropriate applications are updated, and the complete file is maintained in the BCBSIL corporate electronic record storage system (Enterprise Appeal Application). The complete file can also be maintained in a secure area including but not limited to a locked cabinet
I. The provider, member and/or member's authorized representative (MAR), and/or facility have the right to submit additional information related to the appeal request under review
J. If the request is related to a case under review by the Medical Operations department, the clinical documentation system is reviewed for additional information

Definitions:

Adverse Determination - a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay, or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated.

Adverse determinations related to the No Surprises Act (NSA) eligible for external review include:

A. Patient cost-sharing and surprise billing for emergency services.
B. Patient cost-sharing and surprise billing protections related to care provided by non-participating providers at participating facilities.

C. ***Whether patients are in a condition to receive notice and provide informed consent to waive NSA protections***
D. ***Whether a claim for care received is coded correctly and accurately reflects the treatments received and the associated NSA protections related to patient cost-sharing and surprise billing.***

Note: Cost-sharing is the share of costs covered by your insurance that you pay out of your own pocket. This term generally includes deductibles, coinsurance, and copayments, or similar charges.

Clinical Appeal - an appeal regarding adverse determination of a service that is a covered benefit in the Certificate of Healthcare Benefits or could be considered to be a covered benefit depending upon the circumstances, when the basis for the appeal is clinical in nature. ***Appeals are not considered to be clinical appeals when there is no clinical basis for the appeal. Examples*** of clinical appeals include:

A. Appeals involving an adverse determination based on the lack of medical necessity.
B. Appeals regarding an experimental or investigational service.
C. Appeals regarding a cosmetic procedure when the basis for the appeal is that the service is needed for other than cosmetic reasons.
D. Appeals for access to an out-of-network practitioner or provider when the basis for the appeal is that access to a practitioner or provider with appropriate clinical expertise has not been provided.

Clinical Peer - a practitioner or health professional who must:

A. Hold a current active, unrestricted license to practice medicine or a health profession in a state or territory of the United States
B. Unless expressly allowed by the state or federal law or regulation, are located in a state or territory of the United States when conducting an appeals consideration;
C. Be board certified by a specialty board approved by the American Board of Medical Specialties (Doctor of Medicine); or the Advisory Board of Osteopathic Specialists from the major areas of clinical services (doctors of osteopathic medicine); (Note: Board certification requirement is not applicable to provider types other than doctors of medicine and doctors of osteopathic medicine.)
D. Are in the same profession and in a similar specialty as typically manages the medical condition, procedure, or treatment under review.

Note: A physician reviewer may at any time defer to evaluate an appeal if they feel that they do not have the specific clinical expertise to evaluate a particular service.

External Peer Review - a request for an independent, external review of the final adverse determination made through the internal appeal process.

Final Internal Adverse Determination - an Adverse Determination involving a covered benefit that has been upheld by a health carrier, or its designee utilization review organization, at the completion of the health carrier's internal grievance process procedures as set forth by the Managed Care Reform and Patient Rights Act.

Health Care Services - any service included in the provision of medical care, as outlined in the Member's Certificate of Health Care Benefits, for the purpose of preventing, alleviating, curing or healing human illness or injury.

Non-Urgent Appeal - a pre-service or post-service appeal that does not meet the urgent care expedited appeal criteria.

Post service Appeal - a request to change an Adverse Determination for care or services that have already been received by the member.

Pre-service Appeal - a request to change an Adverse Determination for care or services that must be approved in whole or in part in advance of the member obtaining care or services.

Provider - any physician or other healthcare professional, institution or organization providing medical care, equipment or supplies to the patient. (Examples: hospitals, skilled nursing facilities, home healthcare agencies, DME suppliers.)

Standard Clinical Appeal - an appeal regarding denial of a service that is a covered benefit in the Certificate of Healthcare Benefits or could be considered to be a covered benefit depending upon the circumstances, when the basis for the appeal is clinical in nature. Examples of clinical appeals include:

A. Appeals involving services denied on the basis of lack of medical necessity.
B. Appeals regarding an experimental or investigational service.
C. Appeals regarding a cosmetic procedure when the basis for the appeal is that the service is needed for other than cosmetic reasons.
D. Appeals for access to an out-of-network practitioner or provider when the basis for the appeal is that access to a practitioner or provider with appropriate clinical expertise has not been provided.

Note: Appeals are not considered to be clinical appeals when there is no clinical basis for the appeal.

Procedure:

A. For ASO members, the timeframe for completion of this process is 30 calendar days for pre-service and post-service appeals, and for fully insured (FI) members, 15 business days for pre-service and post-service appeals from receipt of the request to written notification of the appeal determination.

Note: If an employer group has multiple levels of appeal, each appeal will be processed with equally separated time. Example: 2 levels=each level 15 days.

B. All information received will be considered and investigated during the appeal process regardless of whether it was reviewed during the initial review
C. The provider, member, and/or facility have the right to submit additional information related to the appeal request under review. If the request is related to a case under review by the Medical Management department, the clinical documentation system is reviewed for additional information.
D. The appeal staff documents the substance of the appeal and forwards the appeal file to the designated appeal Medical Director (MD) for review including:
    1. The member's reason for appealing the previous denial,
    2. The date the appeal was received.
    3. Additional clinical or other information provided with the appeal request.
    4. Documentation of all previous reviews and appeals including the reviewer and date of review.

5. Notation of follow-up actions taken from previous reviews and/or appeals.
6. Resolution of at each level of the internal appeal, if applicable.
7. The date of resolution at each level, if applicable.
8. The name of the covered person for whom the internal appeal is filed.

E. The appeal MD reviews the clinical documentation submitted. The appeal will be fully investigated including any clinical aspects of care and documents any of its findings.
F. If the appeal MD is a clinical peer, or able to overturn the original denial decision, they document the determination of the case in the corresponding clinical documentation system. The documentation will include:
    1. The appeal determination
    2. The principal reason for the determination and
    3. The clinical rationale, which includes an understandable summary of the medical criteria, benefit provision, guideline or protocol used to make the determination.
    4. Upon receipt of the appeal decision, the designated appeal staff prepares and mails the appeal determination letter to the requesting provider with a copy to the member or the party filing the appeal, the attending physician and the ordering provider and/or facility. If the determination is adverse, the written notification will include:
    5. The appeal determination,
    6. The principal reason for the determination,
    7. The clinical rationale, which includes an understandable summary of the medical criteria, benefit provision, guideline or protocol used to make the determination
    8. A statement that the specific medical criteria or benefit provision used in making the determination will be provided upon request,
    9. A statement and copies of all documents relevant to the member's appeal will be provided upon request, free of charge.
G. If the designated appeal MD is unable to overturn the original denial decision and is not a clinical peer, they will:
    1. Determine if there is an alternate in-house specialty matched clinical peer,
    2. Verify that the in-house clinical peer physician was not involved in any previous adverse determination and forward the complete file to the alternate physician.
    3. The peer physician reviews the appeal file, makes a determination, and documents the following in the corresponding clinical documentation system case:
        a. The appeal determination
        b. The principal reason for the determination and,
        c. The clinical rationale, which includes an understandable summary of the medical criteria, benefit provision, guideline or protocol used to make the determination.
        d. The peer physician returns the appeal file to the designated appeal staff.
H. Upon receipt of the appeal file, the designated appeal staff:
    1. Provides verbal notification of the appeal decision to the requesting provider, member and facility or the party filing the appeal.
    2. Prepares and mails the appeal determination letter to the requesting provider with a copy to the member or the party filing the appeal, the attending physician and the ordering provider and/or facility.
I. If the determination is adverse, the written notification will include:
    1. The appeal determination
    2. The principal reason for the determination,
    3. The clinical rationale, which includes an understandable summary of the medical criteria or benefit provision used to make the determination provided in member friendly rationale that are culturally and linguistically appropriate manner.

4. A statement that the specific medical criteria, benefit provision, guideline or protocol used in making the determination will be provided upon request,
5. Additional appeal rights (if applicable),
6. The appeal reviewer's credentials and sub-credentials, specialties and subspecialties,
7. A statement that copies of all documents relevant to the member's appeal will be provided upon request, free of charge.

J. If there is no alternate in-house specialty matched clinical peer to review the appeal, the file is returned to the designated appeal staff, who will do the following:
   1. Submit the external peer review request indicating the specialty required and the timeframe for completion.
   2. The pertinent medical information is copied and sent for external peer review via overnight delivery or by HIPAA-Secure electronic means.
   3. The complete file is retained in an electronic format within the BCBSIL corporate electronic record storage system the (Enterprise Appeal Application). The complete file can also be maintained in a secure area including but not limited to a locked cabinet to await the external peer review recommendations.

K. Upon receipt of the appeal determination from the external peer reviewer, the designated appeal staff:
   1. Provides verbal notification of the appeal decision to the requesting provider, member and facility or the party filing the appeal.
   2. Prepares and mails the appeal determination letter to the requesting provider with a copy to the member or the party filing the appeal, the attending physician and the ordering provider and/or facility. If the determination is adverse, the written notification will include:
      a. The appeal determination,
      b. The principal reason for the determination,
      c. The clinical rationale, which includes an understandable summary of the medical criteria, benefit provision, guideline or protocol used to make the determination and statement that the specific medical criteria or benefit provision used in making the determination will be provided upon request.
      d. The letter should include the reason for upholding the denial in terms specific to the member's condition or request and in language that is easy to understand and member friendly: (Example: Acronyms and health procedure codes should be defined),
      e. Additional appeal rights (if applicable),
      f. The appeal reviewer's credentials and sub-credentials, specialties and subspecialties,
      g. A statement that copies of all documents relevant to the member's appeal will be provided upon request, free of charge.
      h. A statement that the member may request an external independent review (except for commercial grandfathered plans).

L. Non-clinical appeals will be reviewed by an appeal specialist who was not involved in the initial denial and the written notification will include:
      a. The appeal determination
      b. The principal reason for the determination,
      c. A statement that the specific medical criteria, benefit provision, guideline or protocol used in making the determination will be provided upon request,
      d. Additional appeal rights (if applicable),
      e. A statement that copies of all documents relevant to the member's appeal will be

provided upon request, free of charge.

M. Post-service overturned adverse determinations must be routed to appropriate appeals staff for timely claim adjustment.
N. BCBSIL maintains records for each appeal that includes:
    1. The name of the patient, provider, and/or facility
    2. Copies of all correspondence from the patient, provider or facility rendering service and BCBSIL regarding the appeal
    3. Dates of appeal reviews, documentation of actions taken and final resolution
    4. Name and credentials of the clinical peer reviewer

System Controls

A. Upon entering the Appeals Department (Appeals Specialists), or RIG (Regulatory Inquiry Group) Department (Inquiry specialist and Customer Advocate Specialist), staff are trained and granted access to the Enterprise Appeal Application (EAA) via corporate security access request. Any changes made to information in the EAA, have a date, time and user ID stamp that is created upon the adjustment. This allows for an additional layer of security for the record in the event a field would be modified. Once a record is closed in the EAA, adjustments are only available to users that have been granted an additional level of security, noted as a "super user" via an additional corporate security access request. Please see corporate security policies T.01, T.02, T.07 ST.07.02, and ST.01.01A which also includes:

    1. Limiting physical access to the system.
    2. Preventing unauthorized access and changes to system data.
    3. Password-protecting electronic systems, including requirements to:
        a. Use strong passwords
        b. Discourage staff from writing down passwords
        c. Use different passwords for different accounts
        d. Change passwords when requested by security management or if passwords are compromised
        e. Ensure user IDs and passwords are unique to each user
    4. Disabling or removing passwords of employees who leave the organization and alerting appropriate staff who oversee computer security.

B. Upon receipt of a valid appeal, the date and time is recorded in the EAA as the Corporate Receipt Date (CRD). This date could be based on, but is not limited to, a Julian date, FAX date and time stamp, phone call receipt date and time, correspondence date, email date, or secured message date, etc.

C. The Appeals, Inquiry, or Customer Advocate Specialist will verify that the Corporate Receipt date (CRD) entered in the EAA matches the date on the appeal request source. CRD can only be updated by employees (supervisors, support staff, and team leads) with additional security clearance (super user) if an error in the CRD is discovered. This is the only instance in which the date can be modified. When the record is updated by these employees, the user's individual identification number is captured by the system, along with the date and time of the new CRD. The system prompts for additional notes to explain why the date was modified and the modification made. This ensures that only specific individuals can perform this level of update, and the reason for the update is documented/recorded.

D. Additional notification dates, if applicable are documented automatically by the system in EAA:
    1. The date of verbal notification
    2. The finalized date. This date is entered by the EAA when letters are finalized by the Appeals Specialist
    3. The date the determination letter (written notification) is generated and mailed is auto populated and cannot be edited by the Appeals Specialist or by any other employee. The determination letter outlines any applicable rights and next steps available
E. Auditing Process for System Controls:
    1. Compliance monitoring staff will randomly select appeal files to audit monthly using a sample of 5% or 50 Utilization Management (UM) appeal files, whichever is less.
    2. Feedback will be provided to the appeals team quarterly, after review of monthly trending. Quarterly reports are reviewed to assess compliance with BCBSIL UM system controls policies and procedures.
    3. If modifications do not meet the organization's policies and procedures:
        a. A qualitative and quantitative analysis of findings will be conducted.
        b. All actions taken to address any date modifications that did not meet BCBSIL's policies and procedures will be identified and documented. BCBSIL will implement quarterly monitoring to assess the effectiveness of its actions on all findings.
        c. Monitoring will continue until improvement is demonstrated over three (3) consecutive quarters.

Revision History

Date	Changes Made
12/09/2022	Annual Review, updated Adverse Determination definition to include No Surprises Act (NSA), updated Clinical appeal definition to include a note showing appeals are not considered to be clinical appeals when there is no clinical basis for the appeal, added revision history at the end of policy, updated formatting changes.