BlueCross BlueShield of Illinois

Health Care Delivery Policy and Procedure

Policy Name: **Provider Urgent/Expedited Clinical Appeal Process**
Policy Number: Utilization Management - 06
Effective Date: 09/16/02
Revision Date: **12/01/2022** **Review Date: 12/01/2022**

Approval Signature

DSVP IL Health Care Delivery

Line of Business

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

Approving Body

☒ Policy and Procedure Committee Date: 11/17/2022

Details

Policy:

Blue Cross and Blue Shield of Illinois (BCBSIL) will review Provider Urgent/Expedited 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.

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 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. The appeal process will include a full investigation/review of the case, including all aspects of clinical care involved and documentation of any findings. The organization's appeal review does not give deference to the denial decision

H. 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

I. 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

J. 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

K. 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.

Clinical Appeal - ***an appeal regarding an Adverse Determination of a service that is a covered benefit in the benefit plan document or could be considered to be a covered benefit depending upon the circumstances, when the basis for the appeal is clinical in nature or an adverse benefit determination eligible under Section 110 of Title I No Surprises Act (NSA). Examples of clinical appeals include:***

A. Appeals involving an Adverse Determination of services 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.

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

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 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. Be in the same profession and in a similar specialty as typically manages the medical condition, procedure, or treatment under review.
E. Neither be the individual who made the original Non-Certification, nor the subordinate of such an individual.
F. Does not give deference to the initial review.

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

Expedited Appeal – a pre-service or concurrent request to change an adverse determination for urgent care

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

Final 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.

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 member. (Examples: hospitals, skilled nursing facilities, home healthcare agencies, Durable Medical Equipment (DME) suppliers.)

Urgent Care - a request for medical care or treatment with respect to which the application of the time-periods for making non-urgent care determinations:

A. Could seriously jeopardize the life or health of the member, or the member's ability to regain maximum function, based on a prudent layperson's judgment or
B. In the opinion of the practitioner with knowledge of the member's medical condition,

would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

Procedure:

Urgent Care / Expedited Pre-service and Concurrent Clinical Appeals:

A. Appeals may be requested verbally or in writing. For provider submitted urgent / expedited clinical appeals, the provider and/or any other party other than the member must advise they are appealing on behalf of the member to be considered a member appeal
B. A member authorization is not required for provider submitted urgent / expedited clinical appeals.
C. The decision time frame for completion of urgent care / expedited pre-service and concurrent appeal requests is no later than 72 hours from receipt of the appeal request followed by written notification within three (3) calendar days
D. Following receipt of a verbal or written appeal request, via fax, mail, or telephone call, the designated appeal staff will review the information received to confirm that it is complete. Urgent care / expedited will confirm within 24 hours of request
E. If incomplete documentation has been submitted:
    1. Within 24 hours of receipt of the urgent / expedited appeal request, the appeal staff verbally informs the appealing party of the specific information necessary to complete the appeal
    2. The appealing party shall be afforded a reasonable amount of time, considering the circumstances, but not less than 48 hours to provide the specified information for urgent / expedited appeals
    3. The substance of the appeal will be documented, and a full investigation will be completed
F. Upon receipt of additional information, the appeal will be updated with the new information. If the additional information is not received within the specified time frame listed above, a determination is made based on the available information, with verbal and written notification provided to the requesting provider, member, facility and/or the party filing the appeal
G. BCBSIL will provide a copy of any additional evidence, new information, or new rationale relied upon or generated by BCBSIL to the appellant free of charge prior to rendering a determination. This information will be sent without request (Full & Fair review)
H. Upon receipt of the clinical peer decision:
    1. Designated appeal staff reviews and forwards case to complete verbal and written notification
    2. Designated appeal staff performs verbal notification of the decision to the member, Member's authorized representative (MAR), appellant, attending physician, ordering physician and/or facility
    3. Designated appeal staff issues written notification of the decision to all parties. The written notification will include:
        a. The appeal determination
        b. The clinical rationale, which includes an understandable summary of the medical criteria, benefit provision, guideline or protocol used to make the determination
        c. Description of or the source of screening criteria, benefit provisions, guidelines, and/or protocols that were used in making the determination such as the member's benefit book and citing rationale for the decision in member friendly language
        d. A reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based
        e. A statement that the specific medical criteria or benefit provision used in making the determination will be provided upon request, free of charge
        f. The titles and qualifications of the individual(s) participating in the appeal review including but not limited to titles, credentials, specialties, sub-specialties, and expertise
        g. Information in a culturally & linguistically appropriate manner
        h. Additional appeal rights as available
I. If the designated appeal clinical reviewer overturns the original denial:
    1. The appropriate applications are updated, and the complete file is maintained in the BCBSIL corporate electronic storage system (Enterprise Appeal Application)
J. If the designated appeal clinical reviewer partially overturns or maintains the initial denial during the evaluation, the written notification will include:

1. A description of the procedure for requesting an external independent review

2. The timeframe for submission of an external appeal request
3. The member's right to designate someone to act on their behalf
4. Language confirming the external reviewer's decision is binding
5. A statement that benefits beyond those included in the benefit certificate are not eligible for external review
6. A statement that there is no cost to the member should they request external review

System Controls

A. Upon entering the Appeals Department (Appeals Specialists), or RIG (Regulatory Inquiry Group) Department (Inquiry 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

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, and the system automatically 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 the 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
09/09/2022	Annual Review, updated Clinical appeal definition to include No Surprises Act (NSA), Changed wording on G under guidelines
05/18/2022	Changes to System Controls
07/19/2021	P&P Standardization & updated Language services & System Controls
09/20/2020	Annual Review, updated to member friendly language