

# Appeals

## ***Member Appeals***

Health plan member appeals should be easy to understand, so we're sharing this brief summary to make you aware of the important steps and critical timeframes if you, the provider, choose to use this process, with the member's permission, on their behalf. The Washington state Patient Bill of Rights requires that health plans tell members about the right to appeal, and other member rights and responsibilities, annually, when the member enrolls and upon request.

## **Appeal Types, Definitions and Timeframe**

### **Definitions**

#### **Complaint**

A term commonly used to describe an oral or written expression of dissatisfaction by a member.

#### **Appeal**

A formal request by a practitioner or covered person for reconsideration of a decision such as a utilization review determination, a benefit payment, an administrative action, or a quality of care or service issue, with the goal of finding a mutually acceptable solution.

### **Standard Appeal - Level 1**

#### **What the member must do:**

The member, or someone representing the member, tells us, the member's health plan, about the complaint or appeal in writing or verbally within 180 days of receiving something in writing from us - such as an Explanation of Benefits describing a claim denial or a letter denying a preauthorization request. Explain to us what you're dissatisfied with, based on a previous decision or action by us. The member may give us written materials supporting the complaint or appeal. If the member or the member's provider is asking Asuris Northwest Health to reconsider a previously denied preauthorization, the provider may be able to talk directly with a medical director.

#### **What Asuris Northwest Health does:**

A member service representative accepts and logs the complaint or appeal and notifies the member of receipt within five days. The complaint or appeal is investigated, and an appeal inquiry is prepared. Based on the information submitted and gathered during the investigation, a decision is made. The decision is recorded in writing and sent to the member.

- If the complaint or appeal is related to care that the member has not yet received, the complaint or appeal will be reviewed and a decision will be made within 15 days of receiving the complaint or appeal.
- If the complaint or appeal concerns care that the member has already received, the complaint or appeal will be reviewed and a decision will be made within 30 days of receiving the complaint or appeal request.

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(Member Appeals, Continued)

The decision must be understandable, describe how the member may appeal our decision and the timing required, list the people at our health plan who helped make the decision, state the facts and refer to support documents. After receiving this response, the member may ask us to reconsider by proceeding to Standard Appeal Level 2.

## **Standard Appeal - Level 2**

**What the member must do:**

The member, or someone representing the member, must tell us in writing or verbally within 180 days of receiving the Level 1 decision notification that they want to appeal our decision. The member may give us written materials supporting the appeal and are invited to appear in person.

**What Asuris Northwest Health does:**

The Correspondence Unit accepts and logs the appeal and notifies the member within five days that it was received. The Appeal Coordinator then sends the member an invitation to the Member Appeal Panel (MAP) review. MAP will review the appeal request, make a decision on the appeal and record it in writing. The decision is sent to the member by United Parcel Service (UPS). The MAP members are new to the case and have not been involved in any previous decision made regarding the original complaint or appeal. A medical director sits on MAP.

- If the appeal is related to care that the member has not yet received, the appeal will be reviewed and a decision will be made within 15 days of receiving the appeal unless we notify the member or the member's representative that an extension is necessary to complete the appeal process; however, the extension cannot delay the decision beyond 30 days of the receipt of the appeal without the members or the members representative's informed, written consent.
- If the appeal is related to care that the member has already received, the complaint or appeal will be reviewed and a decision will be made within 30 days of receiving the complaint or appeal request.

The written decision must be understandable, describe how the member may request another appeal and the timing required, and provide the rationale for the MAP's decision. Copies of the relevant parts of the contract and Medical Policy are included.

If we don't respond within the above timeframes, the member may proceed as if the appeal has been denied, and submit an appeal to Level 3, Independent Review Organization (IRO).

## **Standard Appeal - Level 3**

**What the member must do:**

Tell us in writing or verbally within 180 days of receiving the Second Level decision notification (or our failure to respond to written request to have your appeal heard in person), that you want to appeal our decision

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(Standard Appeal-Level 3, Continued)

## What Asuris Northwest Health does:

The Appeal Coordinator accepts and logs your appeal and notifies you within five days that it was received. The Appeal Coordinator gathers all facts and supporting documents, together with the previous appeal inquiry, and forwards it to an IRO by UPS within three working days of receiving your request for a Level 3 appeal.

An IRO, made up of physicians not associated with our Company and with medical training in the area of your appeal, reviews your case and makes a decision. These physicians are new to the case and have not been involved in any previous decision made about your original complaint or internal appeal. The IRO makes a decision within 15 days after it receives the information necessary for it to make its decision or 20 days after it receives the request for a decision, whichever is sooner, records it in writing and sends it to us (or 25 days in exceptional circumstances where information necessary to make a decision has not been received). Then, we notify you by UPS of the IRO's decision. Our letter to you must be understandable, describe the next appeal level, if any, and the timing required. The letter includes a copy of the IRO's report documenting their finding, stating the facts and referencing the supporting documents.

## Expedited Appeal Process

There is an expedited appeal process for members who need a faster process, either because we determine that delay would jeopardize the member's life or materially jeopardize the member's health or because the treating health-care provider determines that delay could jeopardize the member's health or ability to regain maximum function. In these cases, you go through a process similar to a Standard Appeal Level Two. The difference is that the reviewing "panel" makes a decision within 24 to 72 hours after you tell us that you want an expedited appeal.

If you aren't satisfied with that decision, you may ask for a second level expedited appeal, similar to Standard Appeal Level Three. The difference is that the IRO makes a decision within 24 to 72 hours of receiving the information necessary for it to make its decision or the eighth day after it receives the request for decision, whichever is sooner.

If we don't respond within the timeframes above, the member may proceed as if the appeal has been denied, and request Non-binding Mediation.

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## *Appeal Process for Healthy Options*

### Definitions

- An “**appeal**” is when a member asks for a review of an action. It can be written or verbal. Someone acting on the member's behalf can also ask for it.
- An “**action**” is the denial or limited approval of something the member asked for. It can include:
  - The type or level of service
  - The reduction, suspension, or ending of a service that had been authorized
  - The denial of payment of a service, in whole or in part
  - The failure to provide services or act in a timely manner
- A “**grievance**” is when the member tells us that they are not happy with something that was done. It can be written or verbal.

### Grievance

#### What you must do:

The member, or someone helping the member, can file a grievance. The member’s doctor cannot file a grievance. It can be written or verbal.

#### What Asuris Northwest Health does:

We get and log the member’s grievance. We will tell notify the member that we received it within five days. Asuris Northwest Health will respond to most grievances within 30 days. The response will be verbal or written. We will respond to grievances about clinical issues in writing.

If the member needs assistance filing a grievance, please call Asuris Northwest Health at **1 (800) 669-8791**.

### Standard Appeals

#### What the member must do:

The member must tell us that they want to appeal an action. It can be written, verbal or in person. *The member can also have someone do this for them with the member’s written permission.* It must be done within 90 days after the member receives a letter from Asuris Northwest Health telling the member about an action. The member should tell Asuris Northwest Health what they are not happy with. If the members doctor asks us to look at an approval we already denied, the doctor can talk to a medical director. He or she can do this if he or she did not talk to a medical director when he or she first asked for the approval.

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(Standard Appeals Continued)

What Asuris Northwest Health does:

We will tell the member or the person acting on the member's behalf, that we got the appeal within 5 days. Someone who was not part of the first decision will look into the appeal. He or she will prepare an appeal file. He or she will make a decision about the case. He or she will put it in writing and send the person who submitted the appeal a decision. A medical director will make the final decision if your appeal is about medical necessity or a clinical issue. He or she will be an expert about your condition or disease.

We will review and decide your appeal within 14 days of getting it. We will tell you if we need more time. We cannot wait more than 30 days after we get your appeal to make a decision unless you give us written consent. We cannot take longer than 45 days.

We will decide about your appeal within 20 days (or 30 calendar days if sooner) after we get it if it is about an investigational service you have already had. You can give us more details in writing or in person to help your appeal. You or someone helping you has the right to look at your appeal file at any time during the appeal process.

The decision will be easy to understand. We will tell you how you may appeal, our action, and list who helped make the decision. We will state the facts and refer to support documents. We must cover the services you are appealing if we do not meet the time frames listed in this appeals process.

For appeals about the termination, suspension, or reduction of a service we already approved, you can ask that these services go on. You must file an appeal and ask for these services to go on within 10 calendar days of the date we sent you the letter that told you about the termination, suspension or reduction of service. If you do not ask for an appeal within 10 days and want these services to go on, we do not have to cover them during the appeal and the time frames for Standard Appeals will apply.

If you need help filing an appeal, please call Asuris Northwest Health at **1 (800) 669-8791** and we will help you.

## **Expedited Appeals**

There is a faster process called an expedited appeal. We can do the faster process if we decide that waiting would harm your life or health, if your doctor says waiting could harm your health or ability to get better or if you ask for it. In these cases, your appeal goes through the same process described above except that the people looking at your appeal make a decision as fast as your condition requires or in 3 calendar days, whichever is sooner. If you want to give information about your expedited appeal in writing or in person, you must do this when the expedited appeal is requested. The people looking at your appeal are also new to the case.

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(Expedited Appeals Continued)

To ask for an expedited appeal, tell us why you need the faster decision. If we deny your request for an expedited appeal, your appeal will be done on the time frames outlined for Standard Appeals. We will tell you in writing within 2 calendar days of this decision. We may also call you with this decision.

## **Fair Hearing**

You can have a Fair Hearing through the Department of Social and Health Services (DSHS) if we deny your appeal. You cannot ask for a Fair Hearing for grievances.

You must ask for a Fair Hearing within 90 days from the day you got the letter telling you we denied your appeal. DSHS needs to know what was denied, when it was denied, and why it was denied. You can have someone talk for you at the hearing. If you ask, DSHS may provide you with free attorney help at the hearing. Your doctor may not ask a Fair Hearing for you.

You Fair Hearing request must go to:

Medical Assistance Administration  
Fair Hearings Unit  
P O Box 45533  
Olympia, WA 98504-5533  
FAX (360) 586-7498

If you ask for your Fair Hearing to be done on an expedited basis and it meets the DSHS criteria for an expedited Fair Hearing, DSHS will make a decision within 3 working days from the date they get your request for an expedited Fair Hearing.

## **Independent Review Organization (IRO)**

### **What you must do:**

Tell us you want an IRO review of the Fair Hearing decision. It can be written or verbal. You must do this within 60 days of getting the Fair Hearing decision. If you want an IRO review of a decision to terminate, modify, or reduce a service that would otherwise be covered, you can ask that these services go on. You must ask for an IRO review and for services to go on within 10 calendar days of the date we sent you the letter telling you about the termination, modification or reduction of services. If you do not ask for an IRO review and for services to go on within 10 days, we do not have to cover the services during the IRO review and the time frames for Standard Appeals will apply.

### **What Asuris Northwest Health does:**

We get and log your appeal. We will tell you within 5 days that we got it. We put all facts and supporting documents with the previous appeal file and Fair Hearing information. Then we give it to an Independent Review Organization (IRO) within 3 working days or when you asked for an IRO

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(Independent Review Organization, Continued)

review. An IRO is made up of doctors that are not related to us. They have medical training in the area of your appeal. The IRO looks at your case and makes a decision. These doctors are new to the case. They have not been part of any other decision made about your appeal. The IRO decides in 15 days after it gets what it needs to make a decision or 20 days after it gets the request for a decision, whichever is sooner. Then the IRO records it in writing and sends it to us. This can also happen in 25 days if the IRO does not get what it needs to make a decision. We will tell you by certified mail of the IRO's decision. You will be able to understand our letter. It will also tell you the next appeal level, if any, and the timing required. It will list the doctors who made the decision, state the facts and refer to support documents.

There is a faster IRO process if we decide that a waiting could harm your life or health. You can also use the faster IRO process if your doctor says waiting could harm your health or your ability to get better. In these cases, you go through an IRO review process like the one above. The difference is that the IRO must decide within 72 hours after you tell us you want an IRO review.

## Board of Appeals

You have the right to a Board of Appeals review through the Department of Social and Health Services (DSHS) if the IRO appeal is denied. You must ask for this in writing and clearly identify why you disagree with the IRO decision and include evidence that backs up your disagreement.

You must ask for a Board of Appeal review in writing on or before the 21<sup>st</sup> calendar day after the first Fair Hearing decision was sent to you. The state needs to know what was denied, when it was denied, and why it was denied. You can have someone talk for you at the review. If you ask, you may have free attorney help provided by DSHS at the review.

The request must go to:  
DSHS Board of Appeals  
P O Box 45803  
Olympia, WA 98504-5803  
Toll free 1 (877) 351-0002  
TTD (360) 664-6178

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## ***Provider Appeals***

### **Overview of Appeals/Disputes/Complaints**

From time to time, you may feel that a claim has been adjudicated incorrectly, or there may be extenuating circumstances you believe would make a difference in the outcome of claims payment. The vast majority of your questions and concerns can be resolved quickly and efficiently by simply placing a call to provider customer service or your professional relations representative. If, after talking with a customer service or professional relations representative, you are not satisfied with the outcome you may initiate a formal appeals process.

Please review the definitions below for a recommendation for which process is appropriate for prompt resolution of your issue. The actual steps of each process and a detailed explanation are available within this section of the manual. Please refer to the diagrams and details within the subsequent pages to determine what steps are necessary to initiate the correct process.

We know that when these types of situations occur, you may not know exactly how to proceed or who to call for help. If you are having difficulty determining which process to invoke please contact your professional relations representative, provider customer service or our physician ombudsman.

If you are unsure of who your professional relations representative is, see our Web site at [www.asuris.com/provider/contact/rep/](http://www.asuris.com/provider/contact/rep/) or call 1 (800) 562-2156.

**Note:** *In most cases where the member has an interest, the **Member Appeals** process must be used. To appeal a provider **contract termination**, please refer to the 'Credentialing' section of this manual.*

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## Provider Appeals

There are *three* distinct types of appeals as referenced in the billing dispute section of your participating provider agreement. Prior to seeking arbitration and/or mediation you must exhaust the provider appeal processes.

### 1. Billing Dispute/Claims Review

A claim review should be utilized whenever you have a question about how a claim was processed, including, but not limited to, coding concerns, reimbursement decisions, DRG assignment and/or provider contract administration.

### 2. Internal Provider Appeals

This process can only be initiated by sending a certified letter to the vice-president of provider network management. We recommend utilizing the billing dispute process prior to invoking the Internal Provider Appeals Process. This process can be used to adjudicate disputes between providers and Asuris Northwest Health with the exception of utilization management decisions, contract terminations and member appeals.

### 3. Utilization Management Reconsideration's and Appeals

**Reconsideration:** A reconsideration is appropriate prior to services being rendered or on a *pre-service basis* only. A reconsideration is a telephone review of a utilization management determination between the attending/ordering physician and the Asuris Northwest Health medical director whom conducted the original review.

**Utilization Management Appeals:** In the event you do not agree with a medical necessity determination you may initiate the Utilization Management Appeals Process. This type of appeal is normally done after the services are rendered, or on a post-service basis, and the adjudication of the claim involves a provider write-off amount.

## Billing Dispute Resolution

The vast majority of your questions and concerns can be resolved quickly and efficiently by simply placing a call to provider customer service or your professional relations representative. If, after talking with a customer service or professional relations representative, you are not satisfied with the outcome you may want to initiate the billing dispute resolution process.

The Provider Dispute Resolution Process is designed for disputes regarding claims processing or billing. For provider contract termination appeals, please refer to the 'Credentialing' section of this manual. The Provider Dispute Resolution Process should be initiated only in instances where the member has no interest in the outcome. To initiate a member appeal on your patient's behalf, review the process description in the 'Member Appeals Section' of this manual. To dispute issues on your

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(Provider Billing Dispute Resolution, Cont.)

own behalf, see definitions listed below and then, if applicable, follow the process described in this section.

Provider complains or disputes fall into three categories. They are:

1. **Reimbursement decisions**

When the provider disputes a specific claim adjudication outcome including, but not limited to, correct coding, reimbursement and provider responsibility.

2. **DRG coding**

When the provider disputes the DRG assigned to a hospital claim.

3. **Agreement/contract matter**

When the provider disputes administration of a provider agreement with Asuris Northwest Health.

### Billing Dispute Resolution Invocation (Step 1)

If you feel a claim has been improperly adjudicated or if there are extenuating circumstances you would like to explain, please initiate the billing dispute process by submitting a written request by regular mail to:

Asuris Northwest Health  
**Attn: Billing Dispute**  
P.O. Box 21267  
Seattle, WA 98111-3267

Please send all pertinent information, including copies of original payment vouchers and other documents that will help us investigate the claim in question. Please help us to insure the documents are processed correctly by indicating this is a 'billing dispute' on the documents. After we review all information, we will communicate the resolution to you within 60 days.

If at this point, you continue to disagree with our resolution you may invoke the formal Internal Provider Appeals Process as described on subsequent pages.

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## Internal Provider Appeals Process (Step 2)

The vast majority of your questions and concerns can be resolved quickly and efficiently by simply placing a call to provider customer service or your professional relations representative. If, after talking with a customer service or professional relations representative, you are not satisfied with the outcome you may want to initiate the billing dispute resolution process or the provider internal appeals process.

If you dispute any Company action or determination, Asuris Northwest Health maintains an internal provider appeals process. This formal provider appeals process is used to adjudicate disputes between providers and Asuris Northwest Health. You must exhaust the provider internal appeals process before seeking arbitration or mediation.

### Step One: Invoke Internal Provider Appeals Process

Please submit a written, detailed “Request for Internal Provider Appeal” within 30 days of the action or decision you want to dispute. Send the request via certified mail; return receipt requested, to:

Asuris Northwest Health  
**Attn: Vice-President of Provider Network Management, MS 909**  
**“Internal Provider Appeal”**  
Post Office Box 21267  
Seattle, WA 98111-3267

Also include, at minimum, a detailed description of the disputed issues, the basis for your disagreement, all evidence and documentation supporting your position (except in the case of an audit dispute where submission of newly discovered records will not be considered) and the action you desire from us.

### Step Two: Response from Asuris Northwest Health

We will reconsider the disputed issue and notify you of our determination within 30 days. At our discretion, the internal provider appeal may include peer review or we may ask that you submit additional information to aid our review. We will send our decision to you in writing via certified mail, return receipt requested, within 30 days of our receipt of your “Request for Internal Provider Appeal.”

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(Provider ‘In person Meeting’, Cont. )

### Step Three: Request for an in-person meeting

If you are not satisfied with our response, you may submit a written “request for an in-person meeting” with Asuris Northwest Health via certified mail, return receipt requested, to:

Asuris Northwest Health  
**Attn: Vice-President of Provider Network Management, MS 909**  
**“Request for an In-Person Meeting”**  
Post Office Box 21267  
Seattle, WA 98111-3267

This request must be postmarked no more than 30 days after the date of our response. The request for an in-person meeting must identify in detail all issues for which you request re-evaluation. We will arrange the date, time and place of your requested meeting within 30 days of receiving the request. You will have the opportunity to make an oral statement and respond to questions.

After meeting with you, we will reassess the issues and send you our determination via certified mail, return receipt requested, within 30 days of the in-person meeting. If we cannot complete this assessment within 30 days or need additional information from you, we will pend the decision and notify you within the 30-day timeframe and we will agree upon a new time for each party to respond. If you do not agree with our decision you may initiate arbitration of any final decisions.

### Arbitration and/or Mediation

You must exhaust the Provider Internal Appeals Process before seeking arbitration or mediation. Please refer to your participating provider agreement for detailed information regarding arbitration and/or mediation.

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## ***Provider Utilization Management Reconsideration's and Appeals Process***

You may appeal individual utilization management and medical necessity decisions if you believe additional information sheds new light on the services performed or that an error was made in the decision-making process.

Asuris Northwest Health has a formal process for handling provider complaints regarding utilization management and medical necessity decisions. This document establishes the policies and procedures for this formal Provider Utilization Management Appeals Process. You may only appeal an individual utilization management and medical necessity decision if you believe additional information, not previously reviewed by Asuris Northwest Health, will impact our original decision or an error was made in the decision making process.

The Provider Utilization Management Appeals Process will be initiated only in instances where the member has no interest. To initiate an appeal on your patient's behalf, review the process description in the “Member Appeals Process” document of this manual. To formally appeal utilization management and medical necessity issues on your own behalf, follow the process outlined in this document.

The Provider Utilization Management Appeals Process is not designed for billing disputes. Those issues will be addressed through the Provider Dispute Resolution Process or the Member Appeals Process. For provider contract termination appeals, please refer to the “Credentialing” section of this manual.

### **Decision-Makers**

A registered nurse or masters degree-level social worker (as appropriate within their scope of practice) may make approval decisions based on the new information provided. A medical director makes denial determinations of appealed decisions. All reviewers are required to have current professional licenses.

### **Standards**

Asuris Northwest Health follows various nationally recognized standards for determining coverage of particular services. Where questions exist that cannot be answered by these standards, by literature searches, or by discussion with other Asuris Northwest Health medical directors, Asuris Northwest Health medical directors may consult with independent board-certified, specialty-matched peer reviewers. Copies of the criteria used in making the decision are available free of charge upon request.

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## Reconsideration

A reconsideration is appropriate prior to services being rendered or on a pre-service basis only. A reconsideration is a telephone review of a utilization management determination between the attending/ordering physician and the Asuris Northwest Health medical director who conducted the original review. You may initiate a reconsideration by calling provider customer service and requesting a reconsideration with the medical director.

## Utilization Management Appeals

- 1) *Standard provider utilization management appeal* - should be retrospective in nature (prospective appeals should be initiated through the Member Appeals Process). Appeals may be initiated in writing and should be accompanied by supporting medical information indicating why the original decision should be overturned. Determinations will be made within 30 business days of our receiving necessary information. Notifications will be verbal or written.
- 2) *Experimental and investigational* denial appeals (E&I) follow the standard appeal processes, but decisions are made within 20 business days of our receiving the necessary information.

Please send the request for a Provider Utilization Management Appeal via certified mail, return receipt requested, to:

Asuris Northwest Health  
**Attn: Provider Utilization Management Appeal**  
Post Office Box 21267  
Seattle, WA 98111-3267

If at this point, you continue to disagree with our resolution, you may invoke the formal Internal Provider appeals process as described on previous pages or you may initiate arbitration or mediation of any final decisions.

## Arbitration and/or Mediation

You must exhaust the Provider Utilization Management Reconsiderations and Appeals Process before seeking arbitration or mediation. Please refer to your participating provider agreement for detailed information regarding arbitration and/or mediation.