

# CHAPTER 5: CARE AND QUALITY MANAGEMENT

## UNIT 5: DENIALS, GRIEVANCES, AND APPEALS

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[What Is My Service Area?](#)

The *Highmark Provider Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania, Delaware, West Virginia, and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to two states only. **Where no symbol is present, the information is relevant to all states.**



The PA ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties.



The DE ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.



The WV ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.

## 5.5 MEDICAL NECESSITY DENIALS

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### Introduction

When a determination is made to not authorize a service, the denial could be either for medical necessity **or** benefit related. This section includes information on medical necessity denials. Please see the applicable section in this unit for benefit denials.

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### Physician reviewer

When a provider requests authorization for an admission or a service, but it is determined that the applicable medical necessity criteria are not met, the case is forwarded to a physician reviewer:

- If the physician reviewer disagrees and determines that the service is in fact **medically necessary**, an authorization is issued.
- If the physician reviewer agrees with the initial assessment that the service is **not medically necessary**, a medical necessity denial is issued. Only a physician can render a denial as not medically necessary.

This process applies whether the authorization request was submitted through NaviNet® or initiated by telephone contact with Clinical Services.

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### Behavioral health review process

When Highmark Behavioral Health Services makes the initial assessment that a member's case does not meet the applicable medical necessity criteria, alternative levels of care may be discussed with the requesting provider. If these suggestions are not acceptable to the treating physician or the facility, the behavioral health care manager refers the case to a physician reviewer:

- If the physician reviewer disagrees and determines that the service is in fact **medically necessary**, an authorization is issued.
  - If the physician reviewer's decision is to **not authorize the services**, a verbal notice of non-authorization is given to the provider, and a written notice follows within one (1) business day after the verbal notice.
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### Written notification of denial

Providers are notified verbally, as well as formally by letter, when the decision is made to not authorize a service. NaviNet®-enabled providers also receive denial notifications through the **Referral/Authorization Inquiry** transaction.

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## 5.5 MEDICAL NECESSITY DENIALS, Continued

### Content of denial letter

As required by regulatory and accrediting agencies, denial letters contain very specific information, including the following:

- Identification of the denied service(s) and service date(s), when applicable
- Clinical rationale that provides a clear and precise reason for the decision
- Utilization criteria, medical policy, or benefit provisions used in making the adverse determination
- A statement that a copy of any policy, criteria, guideline, or other information referenced is available upon request (not applicable to Medicare Advantage)
- Suggested alternative level of care, if appropriate
- Suggested alternatives for treatment, if benefits are exhausted
- Information about member and provider appeal rights and the process to initiate an appeal

### Financial responsibility agreement

In accordance with Highmark's policy on denials for medical necessity reasons (including clinical appropriateness as to site of service) or any non-covered services, the member cannot be billed unless he or she has specifically agreed in writing, **in advance of the service**, to be financially responsible for the entire expense. This financial responsibility agreement must specify the procedure to be performed and include an estimate of the cost of the procedure.

**Note:** The general waiver document routinely signed by patients at admission or registration is not sufficient for this purpose.

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## 5.5 BENEFIT DENIALS

### Benefit verification is provider responsibility

It is the responsibility of the provider to verify that the member's benefit plan provides the appropriate benefits before rendering a service. The NaviNet **Eligibility and Benefits Inquiry** transaction provides the information needed to make this determination.

If NaviNet is unavailable, providers can contact the Highmark Provider Service Center for information about benefits for medical services, or Highmark Behavioral Health Services for information about benefits for behavioral health services.

Quick Reference

### Notification of denial

When authorization requests are submitted by telephone contact, the care manager can assist the provider by verifying whether the member's benefit plan provides the specific benefit for the service to be rendered.

If, in fact, the member does **not** have the benefit, the care manager notifies the provider verbally and follows up with a benefit denial letter.

### Member's right to appeal

**Although the provider is not permitted to appeal a benefit denial, the member can do so.** The benefit denial letter addressed to the member provides the information needed to initiate the appeal.

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## 5.5 PEER-TO-PEER CONVERSATION

<b>Purpose</b>	The purpose of the peer-to-peer conversation is to allow the ordering or treating provider an opportunity to discuss a medical necessity denial determination. This process is typically initiated when a peer-to-peer conversation did not occur prior to the initial denial determination.
<b>Peer-to-peer option offered at time of denial notification</b>	<p>Highmark will advise the treating provider of the availability of this process for commercial members when verbally notifying the provider of an authorization denial (if a peer-to-peer conversation has not already occurred). This discussion may help resolve the issue and spare the time and expense of an appeal.</p> <p><b>Note:</b> If the provider chooses to proceed with an appeal, the peer-to-peer option is forfeited and no longer available to the provider.</p>
<b>IMPORTANT!</b>	<b>The peer-to-peer conversation option is <u>not available</u> for Medicare Advantage members.</b>
<b>Process</b>	<p>The provider has <b>two (2) business days</b> after notification of an authorization denial to initiate a peer-to-peer review for commercial members. The provider may initiate the peer-to-peer conversation by calling the dedicated peer-to-peer phone line. The peer-to-peer conversation will be made available <b>within one (1) business day</b> after receiving a request.</p> <p>If the physician who issued the denial is unavailable, another physician reviewer will be available to discuss the case. In the event the peer-to-peer conversation does not result in an authorization, the provider and member will be informed of their appeal rights and procedures.</p>
<b>Initiating a peer-to-peer conversation</b>	<p>To initiate a peer-to-peer conversation, the provider should call the dedicated peer-to-peer toll-free phone number: <b>1-866-634-6468</b>. Hours of operation are from 8:30 a.m. to 4:30 p.m. (EST), Monday through Friday.</p> <p><b>Providers are encouraged to call during hours of operation to speak with a live intake agent who will gather the necessary information and answer any questions.</b> Requests will then be forwarded to the Highmark clinical peer reviewer who made the determination (or an appropriate designee).</p>

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## 5.5 PEER-TO-PEER CONVERSATION, Continued

### Initiating a peer-to-peer conversation (continued)

If an emergent need arises before or after business hours, the option to leave a voicemail message is available. The following information will be needed:

- CASE/REQ# (e.g., REQ-1234).
- Patient's name and Member ID.
- Name of the treating and/or ordering provider requesting the peer-to-peer conversation and the phone number where a Highmark clinical peer reviewer can reach the provider.

The Highmark clinical reviewer will contact the provider within one (1) business day from the time of the request.

### Outcomes of peer-to-peer conversation

If the peer-to-peer conversation or review of additional information **results in an approval**, the physician reviewer informs the provider of the approval.

If the conversation **does not result in an approval**, the physician reviewer informs the provider of the right to initiate an appeal, and explains the procedure to do so.

### naviHealth peer-to-peer conversations



Peer-to-peer conversations should be requested directly from naviHealth for authorization requests for skilled nursing, long-term acute care, and inpatient rehabilitation services for Medicare Advantage members.

To initiate the process, the provider should contact naviHealth via their toll-free telephone number **1-844-838-0929**.

[What Is My Service Area?](#)

## 5.5 PROVIDER APPEALS

What Is My Service Area?

### Overview

Highmark follows an established appeals/grievance process as a mechanism for providers to appeal an adverse benefit determination. This section will describe the specific processes as they apply to providers appealing on their own behalf for services provided to Highmark commercial members. Please see the [Medicare Advantage: Provider Appealing On Own Behalf](#) section of this unit for Medicare Advantage members.

A provider may appeal a medical necessity denial decision, including decisions to deny experimental/investigational or cosmetic procedures. At the time of a denial determination, the provider is informed of the right to appeal and the process for initiating an appeal.

**Note:** In Delaware, the provider appeal processes outlined here apply only to providers participating in Highmark Delaware's provider networks.

### Applicable products

The provider appeal processes described here apply to all Highmark members **except** those with coverage under Highmark's Medicare Advantage products, the Federal Employee Program (FEP), or products sold on the Marketplace Exchange.

- For the provider appeal processes applicable to Medicare Advantage products, please see content later in this unit.
- For information regarding the Reconsideration and Appeal process for FEP, please contact FEP Customer Service:
  - Pennsylvania: **1-866-763-3608**
  - Delaware: **1-800-721-8005**
  - West Virginia: **1-800-535-5266**
- For information regarding appeals in Pennsylvania, Delaware, and West Virginia related to Affordable Care Act (ACA) regulated, under 65 on-exchange products, please call the customer service phone number on the back of the member's identification card.

### Initiating an appeal

Requests for appeals may be submitted either by telephone or in writing.

A provider has **one-hundred eighty (180) days** from the date of the initial denial of coverage in which to file an appeal in all of Highmark's service areas in Pennsylvania, West Virginia, and Delaware.

### Types of provider appeals

There are two types of appeals available to the provider following a medical necessity denial – **expedited appeal** or **standard appeal**. The type of appeal is determined by the urgency of the situation, as well as the physician's assessment of the situation.

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## 5.5 PROVIDER APPEALS, Continued

[What Is My Service Area?](#)

### Types of provider appeals (continued)

Explicit directions for filing appeals appear in the written denial notification, which is sent to the member or the member's representative and the physician and/or facility, as appropriate. This process involves a verbal or written request initiated by the provider to review a determination that denied payment of a health care service for medical necessity. A clinical peer reviewer who was not involved in the original denial must conduct the review.

### Expedited appeal

An **expedited appeal** is used when a member is receiving an ongoing service or a member is scheduled to receive a service for which coverage has been denied, but the treating provider believes that a delay in service will adversely affect the member's health. This process may be used when any of the following circumstances exist:

- A delay in decision making might jeopardize the member's life, health, or ability to regain maximum functions based on a prudent layperson's judgment and confirmed by the treating practitioner; or
- 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; or
- Concerning the admission, continued stay, or other health care services for a member who has received emergency services but has not been discharged from a facility; or
- Concerning a concurrent review.

[Why blue italics?](#)

### Standard appeal

A **standard appeal** is used for preservice denials in non-urgent situations **and** also for appeals of a post-service denial decision, including denials resulting from retrospective reviews of services rendered without the required authorization.

It is also used as a secondary appeal level when a denial is upheld under the expedited appeal process. In West Virginia and Delaware, provider appeal rights are exhausted after the standard appeal.

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## 5.5 PROVIDER APPEALS, Continued

[What Is My Service Area?](#)

### Highmark's appeal review process follows all applicable accreditation requirements

Highmark's process for reviewing appeals follows all applicable accreditation requirements. These include the following components:

- Review by a clinical peer reviewer who is board certified and holds an unrestricted license and is in the same or similar specialty that typically manages the medical condition, procedure, or treatment under review.
- Reviewer is neither the individual who made the original decision nor the subordinate of such individual.
- Review of the appeal within time frames established by the applicable regulations and standards.
- Verbal (as applicable) and written communication of the decision within time frames established by the applicable regulations and standards.

### Responsibility for medical treatment and decisions

Under all circumstances, the member and the physician bear ultimate responsibility for the medical treatment and the decisions made regarding medical care. Providers and Highmark employees involved in utilization management decisions are not compensated for denying coverage nor are there any financial incentives to encourage denials of coverage.

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## 5.5 EXPEDITED PROVIDER APPEAL PROCESS

[What Is My Service Area?](#)

### Expedited appeals process

This process applies in situations where decisions need to be made in an urgent manner prior to services being rendered **or** for continued stay decisions following a concurrent review denial. All concurrent service appeals are considered urgent.

**Note:** The expedited appeal process is **not applicable** when the service has already been rendered.

EXPEDITED PROVIDER APPEAL PROCESS	
<p><b>How to Initiate</b></p>	<p><b>Contact Clinical Services to initiate an expedited appeal.</b> Clinical Services may request additional information to be faxed if needed.</p> <ul style="list-style-type: none"> <li>• Pennsylvania:                             <ul style="list-style-type: none"> <li>• Western Region Facilities: <b>1-800-242-0514</b></li> <li>• Western Region Professional Providers: <b>1-800-547-3627</b></li> <li>• Central Region Facilities: <b>1-866-803-3708</b></li> <li>• Central Region Professional Providers: <b>1-866-731-8080</b></li> <li>• Northeastern Region: <b>1-800-452-8507</b></li> </ul> </li> <li>• Delaware:                             <ul style="list-style-type: none"> <li>• For IP/OP medical requests: <b>1-800-572-2872</b></li> <li>• For IP/OP behavioral health requests: <b>1-800-421-4577</b></li> </ul> </li> <li>• West Virginia: <b>1-800-344-5245</b></li> </ul>
<p><b>When to Initiate</b></p>	<p>Prior to the member’s discharge from the facility or before rendering services, but within the applicable time frame from receipt of the denial notification.</p> <p>The expedited appeal must be initiated within <b>one hundred eighty (180) days</b> from receipt of the denial notification in all of Highmark’s service areas in Pennsylvania, West Virginia, and Delaware.</p>
<p><b>Decision Time Frame</b></p>	<p>As expeditiously as the member’s health requires, but <b>not to exceed seventy-two (72) hours</b> from receipt of the appeal request, a decision is rendered to uphold or reverse the original denial.</p> <p><b>Note:</b> For Act 68 expedited appeals in Pennsylvania, the decision time frame is <b>not to exceed forty-eight (48) hours</b>. Please refer to the section later in this unit titled “Expedited Grievance: Filing On Behalf of a Member (PA Act 68)” for additional information.</p>

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## 5.5 EXPEDITED PROVIDER APPEAL PROCESS, Continued

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**Notification  
of decision**

The appropriate parties will be notified of the determination by telephone, followed by written notification. Written notification will include, but not be limited to, the following information:

- Reason/clinical rationale for an adverse determination
  - Source of the criteria used to make the determination
  - Right to file a standard appeal and the procedure to initiate it
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## 5.5 STANDARD PROVIDER APPEAL PROCESS

### Introduction

This process applies to preservice denials in non-urgent situations **and** also to appeals of a post-service denial decision, including denials resulting from retrospective reviews of services rendered without the required authorization.

Requests for standard appeals may be submitted either by telephone or in writing.

### When to initiate

A provider must file an appeal within **one hundred eighty (180) days** from receipt of the denial notification in all of Highmark's service areas in Pennsylvania, West Virginia, and Delaware.

[What Is My Service Area?](#)

### Appeal process

The following process is followed for standard provider appeals:

1. The provider submits a request to appeal an adverse medical necessity decision either by calling Clinical Services or in writing to the applicable mailing address (indicated below).
2. A Clinical Services care manager will contact the provider if any additional information is needed to conduct the review and the provider sends it to the Clinical Services care manager.
3. A clinical peer reviewer who was not involved in the original denial decision reviews the case.
4. The provider is notified of the decision by telephone **within thirty (30) calendar days** of receipt of the request and all pertinent information. Written notification is sent to the provider and the member.

### To initiate by telephone

To initiate a standard provider appeal by phone, contact Clinical Services by calling the applicable telephone number for your service area:

#### PENNSYLVANIA:

- Western Region Facilities: **1-800-242-0514**
- Western Region Professional Providers: **1-800-547-3627**
- Central & Northeastern Region Facilities: **1-866-803-3708**
- Central & Northeastern Region Professional Providers: **1-866-731-8080**

#### DELAWARE:

- For IP/OP medical requests: **1-800-572-2872**
- For IP/OP behavioral health requests: **1-800-421-4577**

#### WEST VIRGINIA: **1-800-344-5245**

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## 5.5 STANDARD PROVIDER APPEAL PROCESS, Continued

### Mailing addresses

Submit all pertinent information for to the applicable address below for Commercial appeals. Please see the [Medicare Advantage: Provider Appealing On Own Behalf](#) section of this unit for Medicare Advantage members.

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	PRESERVICE APPEALS	POST-SERVICE APPEALS
<b>Pennsylvania: Western Region</b> (all providers)	Highmark 120 Fifth Avenue Suite P4301 Pittsburgh, PA 15222	Highmark Medical Review P.O. Box 890392 Camp Hill, PA 17089-0392
<b>Pennsylvania: Central, Eastern, &amp; Northeastern Regions</b>	Professional Providers: Highmark Blue Shield Attn: Appeals P.O. Box 890035 Camp Hill, PA 17089-0035  Facilities: Highmark 120 Fifth Avenue Suite P4301 Pittsburgh, PA 15222	Professional Providers: Highmark Blue Shield Attn: Appeals P.O. Box 890035 Camp Hill, PA 17089-0035  Facilities: Highmark Medical Review P.O. Box 890392 Camp Hill, PA 17089-0392
<b>Delaware</b> (all providers)	Highmark BCBSDE, Inc. Medical Management Appeals P.O. Box 1991 Del Code 1-8-40 Wilmington, DE 19899-1991	Highmark BCBSDE, Inc. Medical Management Appeals P.O. Box 1991 Del Code 1-8-40 Wilmington, DE 19899-1991
<b>West Virginia</b> (all providers)	Highmark West Virginia Attention: Appeals Committee P.O. Box 535095 Pittsburgh, PA 15253-5095	Highmark West Virginia Attention: Medical Review P.O. Box 1948 Parkersburg, WV 26102
<b>Behavioral Health Services</b> (all service areas)	Highmark Clinical Services Attn: Behavioral Health 120 Fifth Avenue, Suite P4205 Pittsburgh, PA 15222	Retro Reviews/Standard Commercial Appeals: Utilization Management Attention: Review Committee 120 Fifth Avenue, Suite P4104 Pittsburgh, PA 15222

## 5.5 FILING AN APPEAL ON BEHALF OF THE MEMBER

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### Overview

Any Highmark member has the right to appeal an adverse determination if they are not satisfied with decisions made by Highmark regarding the coverage of services. There are specific federal and state laws and regulations that guide the member appeal process.

Highmark will resolve member appeals in a thorough, appropriate, and timely manner in accordance with the Department of Labor (DOL) Claims Procedure Rule under the Employee Retirement Income Security Act of 1974 (ERISA) and the requirements imposed under the Affordable Care Act (ACA).

The DOL appeal process applies to all group health plans governed by ERISA regardless of whether the group is fully insured or self-funded. Highmark also applies this process to all non-ERISA accounts.

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### Definition of a member appeal

A **member appeal** is a request from a member, or member's authorized representative or a provider (with the member's written consent), to review an adverse benefit determination.

This includes services related to coverage, which include contract exclusions, non-covered benefits, and decisions related to the medical necessity and/or appropriateness of a health care service. This also includes full or partial adverse benefit determinations involving a requested health care service or claim.

This process applies to both pre-service and post-service appeals.

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### Submitting an appeal on behalf of the member

The appeal may be submitted verbally or in writing and should include supporting documentation. Unless requesting an expedited appeal, the following forms must be completed to submit an appeal request in writing:

- Pennsylvania and West Virginia: [Designation of an Authorized Representative](#)
- Delaware: [Designation of Personal Representative for Appeal Processes](#)

These forms can be found on the Provider Resource Center in your service area. Select **FORMS** from the main menu, and then **Miscellaneous Forms**.

If the member appoints a provider as his personal representative, the member may not submit his own appeal concerning the services listed in the Designation form. The member may rescind his Designation (must be in writing) at any time during the process.

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## 5.5 FILING AN APPEAL ON BEHALF OF THE MEMBER, Continued

**Filing time frame** The appeal must be filed no later than **one-hundred eighty (180) days** after receipt of the original denial notification.

**Verbal requests** To submit an appeal request verbally, please contact Highmark by calling the Member Service telephone number on the back of the member’s ID card.

**Written requests** Written appeal requests for Commercial members can be mailed to the appropriate address below. Please see the [Medicare Advantage: Appeals On Behalf of A Member](#) section of this unit for Medicare Advantage members.

<b>PENNSYLVANIA:</b>	
<p><b>Western &amp; Northeastern Regions:</b>                  Member Grievance &amp; Appeals                  Attn: Review Committee                  P.O. Box 535095                  Pittsburgh, PA 15253-5095</p>	<p><b>Central Region:</b>                  Highmark Blue Shield                  Attn: Review Committee                  P.O. Box 890178                  Camp Hill, PA 17089-0178</p>
<b>DELAWARE:</b>	
<p>Highmark Blue Cross Blue Shield Delaware                  Attn: Customer Service Appeals Team                  P.O. Box 8832                  Wilmington, DE 19899-8832</p>	
<b>WEST VIRGINIA:</b>	
<p>Highmark West Virginia                  P. O. Box 1988                  Parkersburg, WV 26101</p>	

[What Is My Service Area?](#)

**FEP members** For member appeals and reconsiderations for the Federal Employee Program (FEP), please contact **FEP Customer Service** for your service area:

- Pennsylvania: **1-866-763-3608**
- Delaware: **1-800-721-8005**
- West Virginia: **1-800-535-5266**

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## 5.5 FILING AN APPEAL ON BEHALF OF THE MEMBER, Continued

### Letter acknowledging receipt

An acknowledgement letter will be sent to the member or to the provider filing on behalf of the member **within five (5) business days** from receipt of the request. The letter will include:

- A description of the appeal process.
- A statement affording the opportunity for the member to submit written comments, documents, or other information relating to the appeal.
- A statement advising that the member, or the member's representative filing on behalf of the member, may have access to information related to the appeal upon request or may submit additional material to be considered.

### Medical necessity appeals

Any appeals related to medical necessity issues are reviewed by a licensed provider in the same or similar specialty that typically treats the medical condition, performs the procedure, or provides the treatment of the service being appealed. The health care provider will not have been involved in any previous adverse benefit determination regarding the subject of the appeal or be a subordinate of any individual that was involved in the adverse benefit determination.

### Benefit related appeals

Appeals regarding benefit denials do not require clinical review. The appeals analyst will determine whether the benefit was applied correctly under the applicable benefit program.

[What Is My Service Area?](#)

### Decision time frame

In Pennsylvania and West Virginia, the member and the provider filing on behalf of the member will be notified of the decision in writing **within thirty (30) calendar days** from receipt of the request.

In Delaware, the member and the provider filing on behalf of the member will be notified of the decision in writing **within thirty (30) calendar days** from receipt of the request for preservice appeals, and **thirty to sixty (30-60) calendar days** for post-service appeals.

Decision letters will provide information on any additional appeal rights that are available.

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## 5.5 FILING AN APPEAL ON BEHALF OF THE MEMBER, Continued

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### Urgent appeals

A request for an **urgent review** of a previous adverse benefit determination for medical, pharmaceutical, or behavioral health services on the basis of medical necessity and appropriateness may be filed by a member, member's authorized representative, or a provider (member written consent is not required; however, physician certification is required).

An urgent request will be considered when any or all of these conditions apply:

- A delay in decision-making might jeopardize the member's life, health, or ability to regain maximum function, or when supported by a provider with knowledge of the claimant's medical condition;
- A delay in decision-making will subject the member to severe pain that cannot be managed without the care or treatment that is the subject of the appeal;
- The request concerns admission, continued stay, or other health care services for a member who has received emergency services but has not been discharged from a facility; and/or
- The request is concerning a concurrent review.

Requests from providers may be received either verbally or in a written format. Provider requests will be accepted as expedited requests. If a member submits the request, Highmark requires the provider to submit a *Physician Certification for Expedited Review* form. The Highmark Member Service Representative will send the form directly to the provider and it should be returned to Highmark immediately.

The appeals analyst will notify the provider and member of the decision by telephone and follow up with a written notification to the member and the provider **within seventy-two (72) hours** of receipt of the request. The expedited appeal decision letter will provide any additional appeal rights that are available.

**Note:** When an urgent appeal is filed, no additional internal appeals are available; this applies even if the member's benefit plan has a two-level internal standard appeal process.

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## 5.5 GRIEVANCE: FILING ON BEHALF OF A MEMBER (PA ACT 68)

### Overview



The Pennsylvania Quality Health Care Accountability Protection Act (Act 68) is legislation enacted to protect the rights of those enrolled in managed care health plans. This act contains provisions that require health plans to establish procedures for member dissatisfactions, complaints, and grievances according to the legislative guidelines.

Any Highmark managed care member has the right to file a grievance for a medical necessity issue or a complaint for a benefit issue, as applicable, if they are not satisfied with decisions made by Highmark. Act 68 gives the provider the option of filing a grievance, but not a complaint, on behalf of the member as long as the provider obtains the member's written consent. An Act 68 grievance can be submitted by or on behalf of a member even in situations in which the member is not financially liable for the services in question.

[What is My Service Area?](#)

### Definitions



A **dissatisfaction** is when a member expresses to the health plan, either verbally or in writing, that he or she is not satisfied with some aspect of the health care plan or delivery of health care services. A dissatisfaction that concerns the managed care network, benefits, quality of care, etc. becomes a formal **complaint** if the member, or the member's authorized representative, requests a review of the matter.

A dissatisfaction becomes a **grievance** when the member, or the member's authorized representative, files a written or verbal request for review of a denial of payment of a health care service **on the basis of medical necessity and appropriateness.**

### Applicable products



The Act 68 grievance process described here applies to these Highmark managed care products in Pennsylvania:

- Commercial HMO products in the Western and Northeastern Regions.
- Children's Health Insurance Program (CHIP) HMO plans in the Western and Northeastern Regions; and CHIP PPO Plus plans in the Central Region.

Although the Act 68 Grievance process applies to HMO commercial plans, even those not governed by the Employee Retirement Income Security Act of 1974 (ERISA), **self-insured employer groups are not obliged to comply with this process.**

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## 5.5 GRIEVANCE: FILING ON BEHALF OF A MEMBER (PA ACT 68),

Continued

### Definition of a member grievance/appeal



A **member grievance/appeal** is a process by which a member or member's authorized representative (or provider on behalf of a member), with the written consent of the member, may file a written or verbal grievance regarding the denial of payment of a health care service on the basis of medical necessity and appropriateness. A grievance may be filed regarding a decision that:

1. Disapproves full or partial payment for a requested health care service; or
2. Approves the provision of a requested health care service for a lesser scope or duration than expected; or
3. Disapproves payment for the provision of a requested health care service but approves payment for the provision of an alternative health care service.

[What Is My Service Area?](#)

### Member's written consent required



A valid written consent, signed by the member, is required before a provider may proceed with the Act 68 grievance process. The [Designation of an Authorized Representative](#) form must be completed in its entirety. This form is available on the Provider Resource Center -- select **FORMS**, and then **Miscellaneous Forms**.

The member may not submit a separate grievance on the same issue without rescinding the consent in writing. The member may rescind consent at any time during the grievance process.

### Filing time frame and address



The appeal must be filed no later than **one-hundred eighty (180) days** after receipt of the original denial notification.

The grievance may be submitted verbally or in writing with supporting documentation and the completed three-page *Designation of an Authorized Representative* form. Verbal grievances can be initiated by calling the Member Service telephone number on the back of the Member ID card. Written grievances can be sent to:

#### Western & Northeastern Regions:

Highmark  
Member Grievance & Appeals  
Department  
P.O. Box 2717  
Pittsburgh, PA 15230-2717

#### Central Region:

Highmark Blue Shield  
Attention: Grievance Committee  
P.O. Box 890174  
Camp Hill, PA 17089-0174

### Billing restrictions



Once a health care provider assumes responsibility for filing a grievance, the provider may not bill the member or the member's legal representative for services that are the subject of the grievance until the grievance process has been completed or the member rescinds consent.

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## 5.5 GRIEVANCE: FILING ON BEHALF OF A MEMBER (PA ACT 68),

Continued

### Letter to acknowledge receipt



An acknowledgement letter will be sent to the member and the provider filing on behalf of the member **within five (5) business days** from receipt of the grievance request.

The acknowledgement letter will include the following information:

- The right to submit additional information to support the appeal.
- Thirty (30) days for resolution.
- Confirmation that Highmark considers the matter to be a grievance rather than a complaint, and that the member, member's representative, or provider may question the classification of complaints and grievances by contacting the Pennsylvania Department of Health.
- Description of the grievance process.
- Member may appoint a representative to act on his or her behalf at any time during the internal grievance process.
- The member, the member's representative, or the provider filing on behalf of the member may review information related to the grievance upon request and also submit additional material to be considered by Highmark.
- A statement advising that the member or the member's representative may request the assistance of a Highmark employee to assist in preparing the first level grievance.

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### Grievance review process – First Level



A provider in the same or similar specialty that typically treats the medical condition, performs the procedure, or provides the treatment will be assigned to review the documentation. The physician reviewer will be an individual who was not involved in any previous adverse benefit determination regarding the grievance and is not a subordinate of any individual involved. The physician reviewer will decide whether to uphold or overturn the initial determination.

The member and the provider filing on behalf of the member will be notified of the decision in writing **within thirty (30) calendar days** from receipt of the request.

The decision letter will contain:

- A statement of the issue under review;
- The basis for the decision;
- The specific reasons for the decision;
- The scientific and clinical rationale for making the decision applying the terms of the plan to the member's medical circumstances;
- Specific references to the plan's provisions on which the decision is based or instructions on how to obtain the specific plan provisions; and
- An explanation of how to file a request for a second level review of the decision and the time frames for requesting a second level review.

*Continued on next page*

## 5.5 GRIEVANCE: FILING ON BEHALF OF A MEMBER (PA ACT 68),

Continued

### Requesting a second level grievance review



It is not necessary for written member consent for each level of the grievance process. A second level grievance request **must be submitted in writing within forty-five (45) days** from receipt of the first level grievance decision.

A hearing notification letter will be sent to the member and to the provider filing on behalf of the member **at least fifteen (15) days** prior to the hearing date. The notification advises the member and the provider filing on the member's behalf that they have the right to attend and appear before the Second Level Review Committee or participate via phone.

[What Is My Service Area?](#)

### Grievance review process – Second Level



The Second Level Review Committee will be made up of three (3) or more individuals who did not previously participate in the decision to deny coverage or payment for the services. The members of the Review Committee shall have the duty to be impartial in their review and decision. A provider in the same or similar specialty who typically treats the medical condition, performs the procedure, or provides the treatment will be assigned. It will be an individual who was not involved in any previous adverse decisions regarding the grievance and will not be a subordinate of any individual previously involved.

The member and the provider filing on behalf of the member will be notified of the decision **within thirty (30) days** from receipt of the grievance request. The decision letter will include specifics of the grievance issue and reasons for the decision, as well as the procedure and time frames for filing a request for an external review. This letter will also advise whether the member/provider has third level external review rights (grandfathered groups), or independent external review rights (non-grandfathered groups).

### Grievance review process – Third Level



**The Third Level grievance review process applies to grandfathered groups only.** Third level review requests must be submitted to Highmark **within fifteen (15) days** from receipt of the second level grievance decision. Within five (5) business days of receiving the request, Highmark will notify the Pennsylvania Department of Health (DOH) and request an assignment of an Independent Review Organization (IRO).

The DOH will randomly select an IRO to review the case and will notify the member and the provider filing on behalf of the member of the assigned IRO. Highmark will forward the case file to the IRO **within fifteen (15) days** of the request. Highmark will send the member and provider notification when the external grievance is filed, which will include a listing of all documents forwarded to the IRO. Any additional information must be submitted within fifteen (15) days of receipt of the notice that the external grievance was filed.

*Continued on next page*

## 5.5 GRIEVANCE: FILING ON BEHALF OF A MEMBER (PA ACT 68),

Continued

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### Grievance review process – Third Level (continued)



The IRO will assign a practitioner in the same or similar specialty who typically treats the medical condition, performs the procedure, or provides the treatment involved in the grievance and who was not involved in any previous decisions related to the grievance. The assigned IRO will review and issue a written decision **within sixty (60) days** of the filing of the request for an external grievance review. The written notification of the decision will be sent to the member, the provider filing on behalf of the member, Highmark, and the DOH. Highmark will implement the IRO's decision within the time frame specified by the IRO.

If the external grievance is requested by a provider, the Plan and the provider must each establish an escrow account in the amount of half the anticipated cost of the review. If the IRO's decision in an external grievance review filed by a provider is against the provider in full, the provider shall pay the fees and costs associated with the external grievance. If the IRO's decision is against the Plan in full or in part, the Plan will pay the fees and costs associated with the external grievance review.

### Independent external review



#### **Independent external review applies to non-grandfathered groups.**

Independent external review requests must be submitted to Highmark **within four (4) months** from receipt of the second level decision letter. **Within five (5) business days** from Highmark's receipt of the external review request, a preliminary review will be conducted to determine whether:

- The member is or was covered at the time the health care item or service was requested or, in the case of retrospective review, was covered at the time the service was provided.
- The adverse determination does not relate to the member's failure to meet the requirements for eligibility under the terms of the plan.
- The member has exhausted the plans internal appeal process, unless the member is not required to exhaust the internal appeal process
- The member/member's representative has provided all the information and forms required to process an external review.

**Within one (1) business day** after completion of the preliminary review, Highmark will issue a written notification to the member and the provider filing on behalf of the member. If the request is not complete, the notification will describe the necessary information needed to proceed.

Highmark will assign an Independent Review Organization (IRO) who will review all information and make a decision **within forty-five (45) days** after the IRO receives the request. The IRO will provide a written decision to the member, the provider filing on behalf of the member, and Highmark.

## 5.5 EXPEDITED GRIEVANCE: FILING ON BEHALF OF A MEMBER (PA ACT 68)

### Overview



A managed care member may request an expedited review at any stage of the Act 68 grievance review process if the member's life, health, or ability to regain maximum function would be placed in jeopardy by delay under the time frames of the standard review process.

As in the standard grievance process, the member has **one-hundred eighty (180) days** from the notification of an adverse benefit determination to file an expedited grievance. Act 68 also gives the provider the option of filing an expedited grievance on behalf of the member.

**Note:** When an expedited grievance is requested, an additional level of internal appeal is not available.

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### Expedited grievance defined



An **expedited grievance** is a request for an expedited review of an initial denial for a medical, pharmaceutical, or behavioral health service based on medical necessity and appropriateness when:

- A delay in decision-making might jeopardize the member's life, health, or ability to regain maximum function based on a prudent layperson's judgment and confirmed by the treating practitioner; *or*
- In the opinion of a practitioner with knowledge of the member's medical condition, a delay would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request; *or*
- It is concerning the admission, continued stay, or other health care services for a member who has received emergency services but has not been discharged from a facility; *or*
- it is concerning a concurrent review.

### Expedited grievance process



Requests from providers may be either verbal or in a written format and will be accepted as expedited requests. If a member submits the same type of request, Highmark requires the provider to submit a *Physician Certification for Expedited Review Form* for verification that the service requires an expedited review. The form is sent directly to the provider and should be returned to Highmark immediately.

Expedited grievances will follow the Second Level review process (see previous section on the standard grievance process), with verbal and written notification of the decision to the member and provider **within forty-eight (48) hours** from receipt of the request.

*Continued on next page*

## 5.5 EXPEDITED GRIEVANCE: FILING ON BEHALF OF A MEMBER (PA ACT 68), Continued

### Expedited grievance process (continued)



It is the responsibility of the member, or the provider filing on behalf of the member, to provide information to Highmark in an expedited manner to allow Highmark to conform to the requirements of the expedited process. The hearing may be held by telephone if the member and/or provider on behalf of the member cannot be present in the short time frame. All information presented at the hearing is read into the record.

If Highmark cannot provide a copy of the report of the same or similar specialist to the member/provider prior to the expedited hearing, Highmark may read the report into the record at the hearing and provide the member and the provider filing on behalf of the member with a copy of the report at that time.

The written decisions to the member and provider on behalf of the member will state the basis for the decision, including any clinical rationale, and the procedure for obtaining an expedited external review.

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### Expedited external review



For grandfathered groups, the member or provider on behalf of the member has **two (2) business days** from the receipt of the expedited grievance decision to contact Highmark to request an expedited external review.

Highmark will submit a request for an expedited external review to the Pennsylvania Department of Health (DOH) **within twenty-four (24) hours** of receipt of the request. The DOH will assign an Independent Review Organization (IRO) **within one (1) business day** of receiving the request for an expedited review. Highmark will then transfer a copy of the case file to the IRO **within one (1) business day** after being assigned to an IRO. The IRO will have **two (2) business days** following the receipt of the case file to make a decision.

For non-grandfathered groups, the written notification of the expedited review decision will state the basis of the decision, including any clinical rationale and the procedure for obtaining an expedited independent external review. The member or provider on behalf of the member has **four (4) months** from the receipt of the expedited grievance decision to request an expedited external review.



## 5.5 EXPEDITED REVIEW PROCESS UNDER THE AUTISM MANDATE (PA ACT 62)

### Overview of autism mandate



Pennsylvania Act 62 requires private insurers to provide coverage for medically necessary diagnostic assessment and treatment of autism spectrum disorders (ASD) to covered individuals under twenty-one (21) years of age.

This mandate applies to any fully insured health insurance policy offered, issued, or renewed on or after July 1, 2009, to groups of fifty-one (51) or more employees. The mandate also applies to any contract executed on or after July 1, 2009, by the Children's Health Insurance Program (CHIP).

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### Expedited internal review process



If the Act 62 ASD mandate is applicable, a covered individual or an authorized representative is entitled to an expedited internal review process upon denial or partial denial of a claim for diagnostic assessment or treatment of ASD, followed by an expedited independent external review process established and administered by the Pennsylvania Insurance Department. A member or authorized representative also has the option to choose the standard appeal process.

The request for an expedited internal review may be submitted verbally or in writing. The mandated expedited review process applies to both pre-service and post-service denials for diagnostic assessment or treatment of ASD.

The expedited internal appeal will be reviewed by the Second Level Review Committee as set forth under Article XXI (Act 68). The Second Level Review Committee is made up of three (3) or more individuals who did not previously participate in the decision to deny coverage or payment for health care services. The committee shall include a licensed physician or an approved licensed psychologist in the same or similar specialty as that which would typically manage or consult on the health care service in question. The members of the review committee shall have the duty to be impartial in their review and decision.

Verbal and written notification of the decision will be issued to you and the member **within forty-eight (48) hours** from receipt of the request. The written decision to the member, member's representative, or provider on behalf of the member will state the basis for the decision, including any clinical rationale, and the procedure for obtaining an expedited external review.

The member, member's representative, or provider on behalf of the member has two (2) business days from receipt of the expedited grievance decision to request an expedited external review.

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## 5.5 EXPEDITED REVIEW PROCESS UNDER THE AUTISM MANDATE (PA ACT 62), Continued

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### Expedited external review



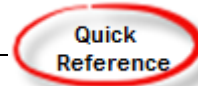
If an adverse determination is upheld by the internal review committee, the covered individual or an authorized representative is then entitled to an expedited external independent review process administered by the Pennsylvania Insurance Department.

An insurer or covered individual or an authorized representative may appeal an order of an expedited independent external review to a court of competent jurisdiction.

### Verify coverage



To determine if a member is covered under the autism mandate, you can verify the member's coverage using the **Eligibility and Benefits Inquiry** function in NaviNet® or by calling the Provider Service Center.



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## 5.5 MEDICARE ADVANTAGE: PROVIDER APPEALING ON OWN BEHALF

### Overview



Providers are entitled to appeal a medical necessity denial decision and are informed of this right at the time of the denial decision. Each appeal is processed in a manner consistent with the clinical urgency of the situation.

The processes as described here apply to members with coverage under one of Highmark's Medicare Advantage products.

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### When the provider can appeal on its own behalf



A provider can make use of this provider appeal process when all of the following are true:

- The provider is contracted with Highmark
- The member has coverage under a Medicare Advantage product
- The services in question have a medical necessity denial determination, including denials for services considered experimental/investigational or cosmetic in nature
- The member is held financially harmless
- The provider seeks a resolution in order to obtain payment for the services

### Types of appeals



Expedited appeals and standard appeals are available to the provider for medical necessity denial determinations.

An **expedited appeal** is a formal review of an initial adverse medical necessity determination. It can be requested when a delay in decision-making may seriously jeopardize the member's life, health, or ability to regain maximum function. Highmark reserves the right to determine whether the request meets the criteria for an expedited appeal.

A **standard appeal** is a formal review of the initial adverse medical necessity determination in which the conditions for expedited appeal are not met. Standard appeal can also be used as a secondary appeal level when a denial has been upheld under the expedited appeal process.

### Member expedited review rights



The Centers for Medicare & Medicaid Services (CMS) requires all Medicare Advantage programs to implement processes for member-initiated expedited review of initial determinations and appeals. Members of all Highmark Medicare Advantage programs, or their representatives, may request a 72-hour expedited review of a service if they believe the member's health, life, or ability to regain maximum function may be jeopardized by waiting for the standard review process. In accordance with CMS guidelines, members may request the initial expedited review without speaking to the PCP first.

*Continued on next page*

## 5.5 MEDICARE ADVANTAGE: PROVIDER APPEALING ON OWN BEHALF, Continued

[What Is My Service Area?](#)

### Member expedited review rights (continued)



Although these processes are largely member-driven, the provider may represent the member and initiate the expedited review. Highmark reserves the right to determine whether the request meets the criteria for an expedited provider appeal. Each appeal is processed in a manner consistent with the clinical urgency of the situation.

The provider must indicate either verbally or in writing that applying the standard time for making a determination could seriously jeopardize the life or health of the member or the member's ability to regain maximum function. The provider need not be appointed as the member's authorized representative in order to make the request.

### Requests for medical records



Providers may be contacted by a Highmark staff member or physician reviewer to supply a copy of the member's medical records in the case of an expedited review. If so, you must supply the records immediately.

Additionally, if you are contacted for information by a physician reviewer about an expedited appeal, you must return his or her call by 8 a.m. the next day. Failure to do so could result in corrective action and/or sanctioning.

### IMPORTANT: Appeals related to naviHealth denials



A denial of post-acute care services will be issued by naviHealth, similar to the approval of services. naviHealth generates the notification of denial of coverage to both the provider and to the patient. If requested, naviHealth also offers a peer-to-peer clinical conversation with the naviHealth Medical Director.

**Any appeal of the preservice or concurrent denial of services rendered by naviHealth will be handled by Highmark, just as appeals are currently handled.** Highmark will continue to handle appeals when the member has not yet been admitted to a post-acute care facility or when the member is still inpatient. Appeals for these situations should be initiated by contacting Highmark Medicare Advantage Expedited Appeals at **1-800-485-9610**.

**naviHealth** will handle appeals after the member has been discharged from the post-acute care facility and a denial has been received. naviHealth can be contacted for **post service** provider appeals as follows:

- Phone **1-844-838-0929**; Fax **1-855-893-5963**
- Address for appeals: naviHealth  
Attention: Provider Appeals  
10 Cadillac Drive, Suite 400  
Brentwood, TN 3702

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## 5.5 MEDICARE ADVANTAGE: PROVIDER APPEALING ON OWN BEHALF, Continued

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### Expedited appeal process



This provider appeal process would apply in situations when a decision needs to be made in an **urgent** manner for a member with Highmark Medicare Advantage coverage. This includes appeals of initial denial determinations prior to services being rendered **and** appeals of denial decisions for continued services following a concurrent review.

The table below explains the process for expedited reviews of initial determinations or appeals for Medicare Advantage members:

EXPEDITED APPEALS	
<b>How to Initiate</b>	<p>Requests for expedited review can be initiated either verbally or in writing.</p> <p>Call the Medicare Advantage Expedited Review Department at <b>1-800-485-9610</b>;</p> <p><b>or</b></p> <p>Fax the information to <b>1-800-894-7947</b>;</p> <p><b>or</b></p> <p>Submit all pertinent medical and other information to:                      Medicare Advantage                      Expedited Review Department                      P.O. Box 534047                      Pittsburgh, PA 15253-5073</p>
<b>When to Initiate</b>	<p>Prior to rendering services, continuing services, or prior to the member's discharge from the facility; but <b>within sixty (60) days</b> from receipt of the denial notification.</p>
<b>Decision Time Frame</b>	<p>As expeditiously as the member's health requires, but <b>not to exceed seventy-two (72) hours</b> from receipt of the appeal request. The 72-hour time frame may be extended by up to fourteen (14) calendar days if the member requests or if additional information is needed.</p>

*Continued on next page*

## 5.5 MEDICARE ADVANTAGE: PROVIDER APPEALING ON OWN BEHALF, Continued

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### Standard appeal process



This provider appeal process applies to initial denial determinations **for services that have already been rendered**, including denials resulting from retrospective review of services rendered without the required authorization.

This process would also apply to appeals for initial preservice denial determinations in non-urgent situations and as a secondary appeal level when an initial denial has been upheld in the expedited appeal process.

The table below explains how the standard review process for Medicare Advantage members works:

STANDARD APPEALS	
<b>How to Initiate</b>	<p>Call the applicable Provider Service Center number:</p> <p><b>PENNSYLVANIA</b></p> <ul style="list-style-type: none"> <li>Freedom Blue PPO: <b>1-866-588-6967</b></li> <li>Community Blue HMO: <b>1-888-234-5374</b></li> <li>Community Blue Medicare PPO: <b>1-866-588-6967</b></li> <li>Community Blue Medicare PPO Plus: <b>1-866-588-6967</b></li> <li>Security Blue HMO (Western Region Only): <b>1-866-517-8585</b></li> </ul> <p><b>WEST VIRGINIA:</b> Freedom Blue PPO: <b>1-888-459-4020</b></p> <p><i>or</i></p> <p>Submit all pertinent medical and other information to:                      Highmark Medical Review                      P.O. Box 890392                      Camp Hill, PA 17089-0392</p>
<b>When to Initiate</b>	Within <b>one hundred eighty (180) days</b> from receipt of the denial notification.
<b>Decision Time Frame</b>	Within <b>thirty (30) calendar days</b> from the receipt of the appeal request.

## 5.5 MEDICARE ADVANTAGE: APPEALS ON BEHALF OF A MEMBER

### Overview



Members of a Medicare Advantage plan have a right to file an appeal if their plan will not pay for, does not allow, or stops or reduces a course of treatment that they believe should be covered or provided.

Ordinarily, it is the member or the member's family who files an appeal if a requested medical service is not authorized; however, the member might ask a provider or other representative to file an appeal on his or her behalf. A provider can do so **only if the member would be financially liable** for the services.

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### Representative statement



The Centers for Medicare & Medicaid Services (CMS) provides an [Appointment of Representative \(AOR\)](#) form (#CMS 1696). This form is also available on the CMS website at:

<https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/index.html>

The member is not required to use the CMS form. They may write their own representative statement appointing a provider or other individual as an authorized representative. The written authorization must contain the following criteria:

- Member's name, Medicare number, address, and telephone number
- Representative's name, address, telephone number, and professional status or relationship to the member
- A statement signed and dated by the member or the individual holding the member's power of attorney authorizing the named person to act as the member's representative in appeal of the denial decision, and acknowledging that he or she understands that personal medical information may be disclosed to this representative
- A statement signed and dated by the appointed representative confirming acceptance of their appointment and agreeing to waive the right to charge a fee for representation
- A statement signed and dated by the provider waiving their right to collect payment from the member for items or services at issue

**EXCEPTION:** In preservice denial situations that meet the criteria for an **expedited** request, the **member's ordering provider** (either contracting or non-contracting) can act as the member's representative *without* a signed representative statement.

### Types of appeals



Two types of appeals are available to the member or to the facility acting as the member's appointed representative:

- Expedited appeal
- Standard appeal

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## 5.5 MEDICARE ADVANTAGE: APPEALS ON BEHALF OF A MEMBER,

Continued

### Expedited appeals



If the member or the member's authorized representative believes that following the standard appeal process would seriously jeopardize the member's life, health, or ability to regain maximum function, an expedited appeal can be requested. The health plan reserves the right to determine whether the request meets the criteria for an expedited appeal.

Highmark will make a decision on an expedited appeal as expeditiously as the member's health requires, but no later than **seventy-two (72) hours** from receipt of the request.

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### Standard appeals



Standard member appeals, including those filed on the member's behalf by a facility, are those that do not meet the criteria for an expedited appeal as determined by the health plan, or those in which the member's health would not be jeopardized by the standard appeal time frame.

Standard appeals are processed as expeditiously as the member's health requires, but no later than **thirty (30) calendar days** from receipt of the request.

### Option for inpatient discharge decisions



When an inpatient in a hospital, a Medicare Advantage member has another appeal option if he or she disagrees with a discharge decision. An immediate review by the Quality Improvement Organization (QIO) can be requested.

**Note:** For more information on this QIO appeal process, please see [Chapter 5.3: Medicare Advantage](#).

### Non-participating providers



A non-participating provider can file a standard appeal on behalf of a Medicare Advantage member for post-service denials only if it submits a *Waiver of Liability* statement with the appeal. The waiver states that the provider will not bill the member regardless of the outcome of the appeal.

Providers that do not participate with Highmark's Medicare Advantage products should follow the standard appeals process as outlined below when appealing a post-service denial.

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## 5.5 MEDICARE ADVANTAGE: APPEALS ON BEHALF OF A MEMBER,

Continued

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### Appeal processes



The table below explains the expedited and standard appeal processes for Medicare Advantage.

	EXPEDITED APPEALS	STANDARD APPEALS
<b>How to Initiate</b>	<p>Call the Medicare Advantage Expedited Review Department at <b>1-800-485-9610</b>.</p> <p><b>or</b></p> <p><b>Fax</b> the request to <b>1-800-894-7947</b>.</p> <p><b>or</b></p> <p>Submit all pertinent information to:                      Medicare Advantage                      Expedited Appeals Department                      P.O. Box 534047                      Pittsburgh, PA 15253-5073</p>	<p>Submit all pertinent information to:                      Highmark Appeals and Grievance Department                      P.O. Box 534047                      Pittsburgh, PA 15253-5047</p> <p><b>or</b></p> <p><b>Fax</b> the information to the Appeals department at <b>717-635-4209</b>.</p>
<b>When to Initiate</b>	<ul style="list-style-type: none"> <li>• <b>Prior authorization denials:</b> Before rendering the service.</li> <li>• <b>Concurrent review denials:</b> Before discharge or continuation of treatment.</li> </ul>	<p><b>Within sixty (60) days</b> from receipt of the denial notification (if good cause is shown, written requests can be accepted after 60 days).</p>
<b>Decision Time Frame</b>	<p>As expeditiously as the member's health requires, but <b>not to exceed seventy-two (72) hours</b> from receipt of the request.</p>	<p>As expeditiously as the member's health requires, but <b>no later than thirty (30) calendar days</b> from the receipt of the appeal request.</p>

### Fourteen (14) day extension



The health plan or the facility filing on behalf of the member may request extensions of up to **fourteen (14) calendar days** for rendering a decision.

Requests for extension must be in the best interest of the member. The health plan must justify the need for the extension and notify the member in writing.

### If a denial on an appeal is upheld



When the health plan renders an adverse decision on an appeal, Highmark automatically forwards the case to the CMS independent review agency and sends a written notification to the member for Medicare Advantage (Part C).

**Note:** For Part D prescription drug coverage, the member or provider must request an appeal through the CMS appeals contractor.

The appeals contractor may request additional information. In such cases, a Highmark Medicare Advantage appeals staff member may contact you for additional information. If you are contacted, please respond to the request immediately.

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## 5.5 MEDICARE ADVANTAGE: APPEALS ON BEHALF OF A MEMBER,

Continued

**If a denial on an appeal is upheld**  
(continued)



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If the CMS independent review agency also renders an adverse decision, the member has the right to initiate further action. The denial communication from the independent review agency includes information about this option.

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## 5.5 PROVIDER APPEAL RIGHTS FOR PRESCRIPTION DRUG BENEFITS

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### Overview

If you are a participating provider with Highmark and you disagree with the decision to deny authorization or payment of a prescription drug for a Highmark Commercial member, you have a right to appeal that decision.

**NOTE:** This section does not apply to Medicare Part D prescription drug coverage.

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### Expedited appeals

Expedited appeals are available when the application of the standard appeal time frame could seriously jeopardize the member's life, health, or ability to regain maximum function, or would subject the member to severe pain that cannot be managed without the care or treatment which is the focus of the appeal.

To request an expedited appeal, please contact Highmark's Prescription Drug Department **by fax at 1-866-240-8123; or by calling 1-800-600-2227.**

You will be permitted to provide additional information over the telephone, by fax, or by other appropriate means. A decision will be rendered within two (2) business days of receipt of your appeal request.

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### Standard appeals

If you are not eligible for an expedited appeal, or if your expedited appeal resulted in an adverse determination, you may initiate a standard appeal.

To request a standard appeal, please contact the Highmark Prescription Drug Department **by fax at 1-866-240-8123; or by calling 1-800-600-2227.**

You will be permitted to provide additional information over the telephone, by fax, or by other appropriate means. A decision will be rendered within thirty (30) days of receipt of your appeal request.

Appeal requests can also be mailed to:

Highmark  
P.O. Box 279  
Pittsburgh, PA 15230-2717  
Attn: Provider Appeal Review Committee

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### Appeals on behalf of a member

Providers can initiate appeals on behalf of the member with the member's written consent. However, if the member gives the provider consent to file an appeal on his or her behalf, then the member is not permitted to file a separate appeal. Member appeal requests must be received within one hundred eighty days (180) of member receipt of denial.

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## 5.5 PROVIDER APPEAL RIGHTS FOR PRESCRIPTION DRUG BENEFITS, Continued

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### Appeals on behalf of a member (continued)

When submitting appeal requests on behalf of a member, you will be asked to provide the following information:

- The member's name, the patient's name, and the group policy number
- The actual drug for which payment was denied and the date of service
- The reasons why you feel the drug should be provided
- Any available clinical information to support your appeal
- Signed consent of member (patient) and provider

Additional information related to member appeal rights will be provided when an appeal request is received.

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### Questions?

If you have questions about your right to appeal, or about how to file an appeal, please call the Highmark Prescription Drug Department at **1-800-600-2227** between 8:30 a.m. and 4:30 p.m., Monday through Friday.

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