Johns Hopkins Health Plans **Appeals** **Appeals**	*Policy Number*	APL012
	Effective Date	07/06/2007
	Review Date	08/10/2016
Subject **EHP Provider Appeals Policy**	*Revision Date*	10/01/2009
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This document applies to the following Participating Organizations:

EHP

Keywords:

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I. ACTION

	New Policy	
	Repealed Policy Date	
X	Superseded Policy Number	APL 004, APL 005, APL 006, APL 007, APL 010

II. POLICY

To provide providers with timely review of appeals and notification of determination in accordance with contractual, regulatory and accreditation requirements.

In the event of an overturn at the first level of appeal, Johns Hopkins Health Plans implements the decision.

Appeals policies and procedures will be made available upon request for any provider.

III. SCOPE

This policy and procedure applies to all appeals requested by providers.

IV. DEFINITIONS

Administrative Appeal – An appeal of a denial, in whole or in part, of payment for a service when the denial was based on fact; administrative appeals are usually the result of an automatic denial.

Adverse Determination - A denial, reduction or termination of, or failure to provide or make payment, in whole or part, for a service. See denial.

Appeal – A request for review of a denial, in whole or in part, of payment for a service, including the type of service; or the reduction, suspension, or termination of a previously authorized service. An appeal includes additional information that was not available at the time of the first determination.

Authorized Representative - Except in the case of urgent care, an individual who by virtue of completion of a Designation of Authorization Representative Form has been designated as acting on the member's behalf

Clinical Appeal - An appeal that involves clinical review; also known as a medical necessity appeal.

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Clinical Peer - A physician who holds an unrestricted license and is in the same or similar specialty as typically manages the medical condition, procedures, or treatment under review.

Clinical Rationale - A statement that provides additional clarification of the clinical basis for denials. The clinical rationale should relate the denial determination to the member's condition or treatment plan and should supply a sufficient basis for a decision to pursue an appeal

Clinical Review Criteria - Guidelines that assist decision making about appropriate health care for specific clinical circumstances. Johns Hopkins Health Plans Clinical Review Criteria includes InterQual Criteria, ASAM (American Society of Addiction Medicine), and SABAC (Scientific Assessment and Benefits Advisory Committee) Medical Policies.

Concurrent Review - Review requested and conducted during a member's inpatient stay or outpatient course of treatment; also known as continued stay review.

Covered Benefit - A health care service for which reimbursement is provided to the provider under the terms of the member's health plan.

Denial - A determination by Johns Hopkins Health Plans that an admission, extension of stay, or other health care service has been reviewed and based on the information provided does not meet the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness. A denial may also refer to a determination that the request does not meet administrative requirements such as benefit coverage, timely notification, or requirement for precertification. A denial is also known as non certification or an adverse determination.

Emergency Medical Appeal - An appeal that requires immediate action to avoid seriously jeopardizing the member’s life or health; also known as urgent appeal.

Expedited Appeal - An appeal of a denial in a case involving urgent care; also known as urgent appeal.

Health Plan - Refers to one of the plans, or lines of business, that Johns Hopkins Health Plans administers. Plans include Priority Partners, US Family Health Plan, and multiple Employee Health Plans.

Medical Necessity Appeal – Determinations on decisions that are (or which could be considered to be) covered benefits, including determinations defined by the organization; hospitalization and emergency services; and care or service that could be considered either covered or non-covered, depending on the circumstances.

Medical Review - The review of a case by a Medical Director or external physician reviewer of the same or similar specialty when the case does not meet clinical review criteria.

Non-Emergency Medical Appeal - An appeal which relates to the health of a member, but is not an Emergency Medical Appeal.

Overturn - An appeal determination made by Johns Hopkins Health Plans that reverses the initial denial decision.

Prospective Review - Review requested and conducted prior to a member's admission, stay, or other service or course of treatments; also known as prior authorization, pre-authorization, pre-auth or pre-service.

Retrospective Review - Review requested and conducted after services have been provided to the member; also known as post service review.

Uphold - An appeal determination made by Johns Hopkins Health Plans that agrees with the initial denial decision.

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Urgent Care Request - Any request for care where the time period for making non-urgent care determinations a) could seriously jeopardize the life or health of the member or the ability of the member to regain maximum function, or b) in the opinion of a physician 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 case.

V. PROCEDURE

A. First Level Appeal

1. Providers may file an appeal if they believe a mistake in denying a claim, or in reducing, terminating or refusing to extend an approved course of treatment occurred, or if they are otherwise dissatisfied with a claim decision.
2. The first level appeal must be filed within 90 business days after notification of the denial.
3. If the denial included a notification of a proposed reduction or termination of an approved course of treatment, and the provider wishes to have a decision on their appeal before the proposed action takes effect, they must file their appeal within 10 days after they are notified.
4. The provider must file a first level appeal within the time allowed or lose all rights to appeal.
5. Except for an appeal of a denial of an urgent care claim, the first level appeal must be in writing. An appeal of an urgent care denial may be submitted in writing or verbally.
6. Written appeals are routed directly from the mailroom to the Appeals Department. If another department receives an appeal in error, that appeal is routed immediately to the Appeals Department.
7. Health Benefit Analysts (HBAs) and/or Appeals Intake Coordinators investigate all appeals on receipt and assign to staff based on the administrative or clinical nature of the appeal.
   a. HBAs are available to evaluate administrative appeals.
   b. All clinical and/or medical necessity appeals are assigned to a Registered Nurse.
8. Appeals Nurse Analysts (Maryland licensed Registered Nurses) research and review all clinical appeals against internal and/or external criteria.
9. The Appeals Nurse Analyst may overturn a first level appeal when documentation submitted on appeal meets applicable criteria and or medical policy.
10. All adverse medical necessity decisions are determined by a Medical Director or external physician reviewer of the same or similar specialty. The decision maker who reviews the case on first level appeal will not have made a prior decision on the case and will not be the subordinate of any person involved in a prior decision.
11. If the member is receiving the covered service, being appealed, prior to the appeal request, that coverage may continue pending the appeal outcome
12. The provider will be notified of the determination in writing within time frames as noted below:

Type of Appeal	Required turn-around time
Urgent care appeal	Within 36 hours after the appeal is filed
Pre-Service appeal	Within 15 days after the appeal is filed
Post-Service appeal	Within 30 days after the appeal is filed
Reduction or termination of an approved course of treatment	Within 30 days after the appeal is filed; if the appeal was filed within 10 days of the denial, the course of treatment will not be reduced or terminated before the appeal is decided.
Request to extend an approved course of treatment	If the appeal was filed before the additional treatment was provided, the Pre-Service Claim time applies. If the appeal was filed after the additional treatment had been provided, the Post-Service claim time applies.

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13. All written determinations will be easily understandable and include:
    a. Specific reasons for the appeal decision in easily understandable language
    b. A reference to the benefit, guideline, protocol or criteria used in the decision
    c. Notification that the provider can request a copy of the benefit, guideline, protocol or criteria on which the appeal decision was based, free of charge.
    d. Notification that the provider, upon request, is entitled to reasonable access and copies of all documentation used in the decision, free of charge.
    e. The title, qualification and specialty of each person involved in the determination decision
    f. An explanation that the provider is entitled to one level of appeal; thus, the first level appeal determination is the final determination.

B. Expedited Appeals
1. Expedited appeals may be submitted verbally or in writing and are immediately forwarded to an Appeals Nurse Analyst or Care Coordinator for review and determination.
2. The process described above will be followed for expedited appeals including review qualifications and written notification requirements.
3. Once the determination has been made, phone notification will be attempted with written notification sent no later than thirty-six hours after receipt of the expedited appeal.

C. Case Retrieval
1. Upon completion of a case, the reviewer is responsible for ensuring that all documentation related to the case is maintained in the case file.
2. All files will include the minimum:
    a. Member name/identification number
    b. Provider name
    c. Date of service
    d. Copies of all correspondence
    e. Documentation of appeal reviews and actions with dates noted
    f. Copy of decision letter
    g. Name and credentials of decision maker
    h. Type of appeal
3. All files are scanned and indexed for storage an retrieval.
4. Upon request, Johns Hopkins Health Plans will provide a copy of the appeal record including copies of all documents relevant to the provider's appeal.

D. Appeal Database
1. Appeals are entered into the MAPET (Member Appeals Processing Event Tracker) system by the Intake staff prior to assigning the case for administrative or clinical review. At a minimum, MAPET includes:
    a. Name and title of the person submitting the appeal (includes member and provider identification)
    b. Date the appeal was received by the Plan
    c. Date the appeal was received by the Appeals Department
    d. Level of appeal
    e. Outcome
    f. Date of case closure and written notification
    g. Name of reviewer

E. Policy Review
1. The Appeals Policy will be reviewed on an annual basis.

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VI. APPROVALS

Reviewed: 1/12/09, 2/23/09, 5/3/09, 10/1/09, 10/1/10,10/1/11, 10/1/12, 10/1/13; 11/14/14; 7/8/15; 8/10/2016

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