JOHNS HOPKINS HEALTH PLANS	Johns Hopkins Health Plans **Appeals** **Appeals**	*Policy Number*	APL014
		Effective Date	07/06/2007
		Review Date	08/10/2016
	Subject **Priority Partners Provider Appeals Policy**	*Revision Date*	06/24/2015
		Page	1 of 5

This document applies to the following Participating Organizations:

Priority Partners

Keywords:

Table of Contents		Page Number
I.	ACTION	1
II.	POLICY	1
III.	SCOPE	1
IV.	DEFINITIONS	2
V.	PROCEDURE	3
VI.	CROSS REFERENCE	5
VII.	APPROVALS	5

I. ACTION

	New Policy	
	Repealed Policy Date	
X	Superseded Policy Number	APL 002, APL 004, APL 005, APL 006, APL 007, APL 010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 (COMAR 10.09.71.03) and accreditation requirements. Both levels of internal appeal offered to Providers will be completed within 90 business days of receipt of the initial appeal request.

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 Provider Appeals.

This policy does not apply to appeal requests submitted by Providers who have been authorized via member's written consent to file the appeal on the member's behalf (COMAR 10.09.71.05(A)(5). Appeal requests of this type should be processed in accordance with the terms outlined in the ***PPMCO Member Appeals Policy*** (APL.013).

This policy does not apply to Expedited/Urgent Appeal request types received from Providers. In accordance with NCQA requirements, the health care provider with knowledge of the member's medical condition (i.e. attending physician; treating practitioner) is allowed to act as the member's authorized representative for Expedited/Urgent appeal requests. Appeal requests of this type are processed in accordance with the terms outlined in the ***PPMCO Member Appeals Policy*** (APL.013).

Providers are not subject to punitive action as a result of utilizing the Provider Complaint Process in accordance with COMAR 10.09.71.03C.

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 – Request for a review of an action.

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. For Expedited/Urgent care decisions, an organization allows a health care practitioner with knowledge of the member's medical condition (e.g., a treating practitioner) to act as the authorized representative (NCQA® 2015 Standards and Guidelines for the Accreditation of Health Plans)

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

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.

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.

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

Health Plan - Refers to Priority Partners MCO, which is administered by Johns Hopkins 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.

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

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

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 was made 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 from the date of denial.
   3. The provider must file a first level appeal within the time allowed or lose all rights to appeal.
   4. The first level appeal must be submitted in writing.
   5. 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.
   6. Appeals Intake Coordinators:
      a. Send a written acknowledgment to the appealing provider within 5 business days of receipt of the appeal.
      b. Assign appeals to staff based on the administrative or clinical nature of the appeal.
         i. Administrative appeals are assigned to Health Benefit Analyst (HBA)
         ii. All clinical (medical necessity) appeals are assigned to an Appeals Nurse Analyst.
   7. Appeals Nurse Analysts (Maryland licensed Registered Nurses) research and review all clinical appeals against internal and/or external criteria.
   8. The Appeals Nurse Analyst may overturn a first level appeal when documentation submitted on appeal meets applicable criteria and/or medical policy.
   9. When the first level appeals decision overturns a claims denial, notification will be forwarded to the Adjustment Department. The claim will be paid within 30 calendar days of the appeal decision.
   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. The Provider will be notified of the determination in writing **within 30 business days** of receipt of the initial appeal request.
   12. All timeframes will be monitored on a weekly and monthly basis.Compliance with timeframes will be reported to the Process Management Team (PMT) on a quarterly basis.
   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. A description of the next level of appeal along with any relevant written procedures

B. Second or Final Level Appeal
   1. If the first level appeal is denied, providers may file a second or final appeal within 20 business days of the date of denial for the 1st level Provider Appeal.

2. The provider must file a second or final level appeal within the time allowed or lose all rights to appeal.
3. The second/final level appeal must be submitted in writing.
4. 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.
5. Appeals Intake Coordinators will:
    a. Send a written acknowledgment to the appealing provider within 5 business days of receipt of the appeal.
    b. Assign appeals to staff based on the administrative or clinical nature of the appeal.
        i. Administrative appeals are assigned to Health Benefit Analysts (HBA) not involved with either the initial review or the first level appeal.
        ii. All clinical and/or medical necessity appeals are assigned to an Appeals Nurse Analyst (Registered Nurse (RN)) not involved with either the initial review or the first level appeal.
6. Appeals Nurse Analysts (Maryland licensed Registered Nurses) research and review all clinical appeals against internal and/or external criteria.
7. All second level appeal reviews are forwarded to a Medical Director or external physician reviewer of the same or similar specialty for determination.
8. The decision maker who reviews the case on second 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.
9. All second or final level appeals will be reviewed by the CEO of Priority Partners.
10. When a second level appeals decision overturns a claims denial, notification will be forwarded to the Adjustment Department. The claim will be paid within 30 calendar days of the appeal decision.
11. The provider will be notified of the determination in writing within **30 business days of receipt of the request for 2nd Level Appeal review**.
12. 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 two levels of appeal; thus, the second level appeal determination is the final determination.
    g. Both the first and second level of appeal will be completed within 90 business days of receipt of the initial 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. Member demographics and eligibility information
    c. Member customer service documentation
    d. Provider name
    e. Date of service
    f. Copies of all correspondence
    g. Documentation of appeal reviews and actions with dates noted
    h. Copy of decision letter

i. Name and credentials of decision maker
j. Type of appeal

3. All files are scanned and available for viewing by the Appeals Department staff.
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. Reporting

1. All timeframes will be monitored on a weekly and monthly basis. Compliance with timeframes will be reported to the Process Management Team (PMT) on a quarterly basis.
2. Aggregate Provider Appeals data will be provided to DHMH in accordance with regulatory requirements.

VI. CROSS REFERENCE

- PPMCO Member Appeal Policy (APL.013)
- NCQA 2015 Standards and Guidelines for the Accreditation of Health Plans
- COMAR 10.09.71.03
- COMAR 10.09.71.05

VII. APPROVALS

Reviewed: 1/12/09, 2/23/09, 4/26/09, 10/1/09, 10/1/10, 10/3/11, 10/1/12, 10/1/13; 10/7/2014; 6/24/15; 8/10/2016