

Appeal Overview

To ensure patient rights regarding their benefit, Comprehensive Behavioral Health Management/College Health IPA (CHIPA) reviews for authorization and advises regarding opportunities for appeal whenever a denial of authorization is issued. The following procedure outlines the process for denial and appeal.

Responsibility

Delegated accounts – When the CHIPA contract includes delegation for denial determinations, CHIPA completes the review process, makes determinations, and communicates the decision to members and providers.

Non-delegated accounts – When the CHIPA excludes delegation for denial determinations, CHIPA completes the review process, including Peer Review, and forwards any denial recommendations to the Health Plan Designee, who then reviews and makes denial determination.

Appeal delegation – All CHIPA contracts exclude appeal reviews. CHIPA assists patients and providers in exercising their appeal rights.

Once an authorization has been granted it cannot be rescinded or modified after the provider renders the health care service in good faith. Pursuant to the authorization for any reason, including, but not limited to the following: the plan's subsequent rescission, cancellation, or modification of the enrollee's or subscriber's contract or the plan's subsequent determination that it did not make an accurate determination of the enrollee's or subscriber's eligibility. CHIPA does not reverse authorization decisions for services provided under an approved authorization. CHIPA closes authorizations for future services once a determination of ineligibility or exhaustion of benefits has been made. Closed authorizations are mailed or faxed to the provider within one business day following eligibility or benefit determination.

Peer Review

If during Initial Review or Concurrent Review a licensed Clinician or UM Coordinator determines that medical necessity is not clear for authorization, the CHIPA Medical Director, a Board Certified Psychiatrist, will be consulted. If the Medical Director concurs, prior to issuance of a denial determination or recommendation to the Health Plan Designee, the provider will be contacted and offered a telephonic Peer Review with the CHIPA Medical Director to occur within 24 hours.

Following Peer Review a determination will be verbally communicated to the patient and provider within 24 hours (e.g., authorization, denial, and/or denial recommendation forwarded to Health Plan Designee).

If the provider chooses not to participate in the Peer Review process, a determination will be made based upon clinical information available and verbally communicated to patient and provider within *UM Timeliness Standards* (Timeliness Standards grid may be accessed online).

When a determination is made to recommend or issue a denial and no peer-to-peer conversation has occurred, the provider of service will be given an opportunity to discuss the

determination with either the peer making the original determination or a different clinical peer within one business day of request. If this peer-to-peer review does not result in approval, the provider of service and the patient will be informed of their appeal rights.

Appeals Process

Appeal Rights

Appeal rights are available upon request to any patient, provider, or POD/Group rendering service. A patient, provider, or facility may submit written documents, records, and other information related to the case. This information is taken into account during the appeals process without regard to whether such information was submitted or considered in the initial consideration of the case.

Expedited appeals are available for all urgent care requests.

Standard Appeals

Verbal appeal instructions are given to the patient and provider at the time a denial determination or recommendation is made by CHIPA. The appeal instructions are included in the denial letter.

Whenever a provider, POD/Group, patient, or patient representative verbally request an appeal review, they are advised that they have 180 calendar days after receipt of denial letter to initiate appeal process. They are given verbal instructions for how to contact their designated health plans and/or the appropriate state agency.

Standard appeals are completed and written notification of the appeal decision issued, within 30 calendar days of the receipt of the request for appeal to the patient and attending physician or other ordering provider or POD/Group rendering the service.

Expedited Appeals

Verbal appeal instructions are given to the patient and provider at the time a denial determination or recommendation is made by CHIPA.

Expedited appeals are completed by the Health Plan Designee with verbal notification of determination to the requesting party within 72 hours of the request followed by written confirmation of the notification within 3 calendar days to the patient and attending physician or other ordering provider or POD/Group rendering service.

Upheld Denial Determinations

If an appeal results in the original denial determination being upheld, the health plan designee will issue a written notification of the adverse appeal decision to the patient and attending physician or other ordering provider or POD/Group rendering the service.

Appeal Reversals

If an appeal results in a reversal of the initial denial decision, the Health Plan Designee will send a letter to the patient and provider. CHIPA will be notified verbally by the Health Plan Designee. An authorization will be created in the patient file and claims paid as needed.