

Beacon Comprehensive Behavioral Health Management Policy and Procedure Manual	
Policy Name: Appeal Process	Utilization Management
Date: 11-08 Last Reviewed by QI Committee: 11-08, 09-09, 10-09, 9-10, 9-11 Last Revised by QI Committee: 09-09, 10-09, 9-11	Page: 1 of 3 Policy Number: UM-6.2

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

Policy:

1.0 Appeal Rights

- 1.1 Appeal rights are available upon request to any patient, provider, or facility rendering service.
- 1.2 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.
- 1.3 Expedited appeals are available for all urgent care requests.

2.0 Appeal Reviewers

- 2.1 Appeal considerations are conducted by health professionals who
 - 2.1.1 Are clinical peers
 - 2.1.2 Hold an active unrestricted license to practice medicine or a health profession
 - 2.1.3 Are board-certified by either the American Board Medical Specialties or the Advisory Board of Osteopathic Specialists.
 - 2.1.4 Are in the same profession and in a similar specialty as the requesting provider
 - 2.1.5 Are neither the individual who made the origination denial determination, nor the subordinate of such an individual.

3.0 Delegation

- 3.1 Beacon CBHM does not have a delegation agreement for appeals.
- 3.2 All appeals are processed through the Health Plan Designee
- 3.3 Beacon CBHM’s role in appeals is to assist members and providers exercise their appeal rights.

4.0 Standard Appeals

- 4.1 Verbal appeal instructions are given to the patient* and provider at the time a denial determination or recommendation is made by Beacon CBHM.
- 4.2 The appeal instructions are included in the denial letter.
- 4.3 Whenever a provider, facility, patient, or patient representative verbally request an appeal review, they are advised that they have 180 calendar days after receipt

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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.

- 4.4 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 facility rendering the service.
- 5.0 Expedited Appeals
- 5.1 Verbal appeal instructions are given to the patient* and provider at the time a denial determination or recommendation is made by Beacon CBHM.
- 5.2 Whenever an expedited appeal is needed due to an urgent care request a Beacon CBHM representative (e.g., UM Coordinators, Director of Intensive Services or Director of Care Management) assists provider to schedule the appeal with the Health Plan Designee.
- 5.3 Beacon CBHM forwards to the Health Plan Designee pertinent clinical information to assist with determination.
- 5.4 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 facility rendering service.
- 6.0 Upheld Denial Determinations
- 6.1 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 facility rendering the service that includes:
- 6.1.1 The principal reasons for the determination to uphold the denial;
- 6.1.2 A statement that the clinical rationale used in making the appeal decision will be provided, in writing, upon request; and
- 6.1.3 Information about additional appeal mechanisms available.
- 7.0 Appeal Reversals
- 7.1 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.
- 7.2 Beacon CBHM will be notified verbally by the Health Plan Designee.
- 7.3 As needed an authorization will be created in the patient file and claims paid.
- 8.0 Documentation
- 8.1 The Health Plan Designee maintains records for each appeal that includes:

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- 8.1.1 The name of the patient, provider, and/or facility rendering service;
- 8.1.2 Copies of all correspondence from the patient, provider, or facility rendering service and the organization regarding the appeal;
- 8.1.3 Dates of appeal reviews, documentation of actions taken, and final resolution;
- 8.1.4 Minutes or transcripts of appeal proceedings (if any); and
- 8.1.5 Name and credentials of the clinical peer that meets the qualifications for appeal reviewer.

*Note: If patient is not available by phone (e.g., they are currently in a facility program), the provider and/or provider's representative is asked to verbally notify the patient.