Excellus BlueCross BlueShield Participating Provider Manual

4.0 Benefits Management

4.1 Utilization Review

> **Note:** This section **does not** apply to the utilization review process for Medicare Advantage products. For information about how the Health Plan conducts utilization review - called "organization determination" by the Centers for Medicare & Medicaid Services (CMS) - for Medicare Advantage products, see Section 10 of this manual.

The Health Plan conducts utilization review to determine whether health care services that have been provided, are being provided, or are proposed to be provided to a member **are medically necessary.**

The Health Plan considers none of the following to be utilization review:

- Denials based on failure to obtain health care services from a designated or approved health care provider as required under a member's agreement.
- Determinations rendered pursuant to the dispute resolution provision of Public Health Law section 2807(c)(3-a).
- The review of the appropriateness of the application of a particular coding to a patient, including the assignment of diagnosis and procedures.
- Any issues related to the determination of the amount or extent of payment other than determinations to deny payment based on adverse determinations.
- Any determination of any coverage issues other than whether health care services are or were medically necessary or experimental/investigational.
- Any denial due to contractual exclusions.
- Any denial for failure to obtain prior authorization where required.

No Financial Incentives

Utilization decisions made by the Health Plan are based on the medical appropriateness of care and service and on the existence of coverage. No one in the organization is compensated for denying coverage or services, either directly or indirectly, and there are no incentive or quota programs. This policy applies to any Health Plan medical or behavioral health staff, management, consultant and/or Medical Director who makes utilization-related decisions.

4.1.1 Utilization Review Criteria

Medical Necessity Determinations

The Health Plan conducts pre-service, concurrent and post-service reviews to determine whether the services requested are appropriate for the diagnosis and treatment of members' conditions. Medical necessity criteria are selected and/or developed and approved by Health Plan medical management committees with input from participating physicians.

Note*:* The fact that a provider has furnished, prescribed, ordered, recommended, or approved a service does not make it medically necessary, nor does it indicate that the service is covered.

Clinical Information/Case Documentation

In an effort to make an informed clinical decision, medical management staff may request copies of selected portions of a member's medical record from all sources involved in the member's care: for example, the member's primary care physician, a physician specialist or an institutional or ancillary provider.

If the documentation supplied is insufficient or requires clarification, the Health Plan Medical Director or designee may call the requesting provider to discuss the case or request additional information.

The Health Plan will review the clinical information supplied against the member's certificate of coverage (hereafter referred to as "contract"); established clinical review criteria; Health Plan standards, guidelines, policies and protocols; and state and federal law and regulations.

Refer to Section 8 of this manual for additional information about submission of medical records.

Criteria Selection and Application

In performing utilization review, the Health Plan utilizes nationally recognized criteria such as InterQual and Medicare medical coverage guidelines, as well as corporate medical policies and protocols, and community-based criteria.

Criteria are reviewed with participating providers. Community-based criteria are developed using regional providers, who apply regional standards of practice as well as nationally accepted standards. Medical management staff uses these standards to evaluate the medical necessity, level of care, and proposed alternative care settings for inpatient and outpatient services. Staff members apply Health Plan medical policies and protocols associated with the requested service. (See discussion about medical policies and protocols later in this Section 4.)

The Health Plan's medical policies and protocols are available through the Provider pages on the Health Plan's Web site. Health Plan utilization management criteria are available to participating providers, members and prospective members upon request from Provider Service and/or Customer Service. (For Health Plan telephone numbers, see the *Contact List* in Section 2 of this manual.)

Review of New Technology and Local Capacity

In an effort to make an informed clinical decision, medical management staff may request copies of selected portions of a member's medical record from all sources involved in the member's care: for example, the member's primary care physician, a physician specialist or an institutional or ancillary provider.

If the documentation supplied is insufficient or requires clarification, the Health Plan Medical Director or designee may call the requesting provider to discuss the case.

The Health Plan will review the clinical information supplied against the member's certificate of coverage (hereafter referred to as "contract"); established clinical review criteria; Health Plan standards, guidelines, policies and protocols; and state and federal law and regulations.

4.1.2 Types of Utilization Review

Pre-Service Review

The Health Plan's medical management staff conducts pre-service reviews on all member services that, according to the individual member's contract, require such determinations before services are rendered. The pre-service review process follows the timeline shown on the chart, *Utilization Review Time Frames*. (See the paragraphs headed *Utilization Review Decision and Notification Time Frames* later in this Section 4.)

A participating provider or a member may initiate a pre-service determination request by telephone, fax or written request, as directed by the terms of the specific benefit plan and the member contract. The staff will assess services in keeping with established preauthorization processes, the member's contract and/or approved medical criteria. Cases not meeting criteria or requiring further evaluation are referred to a Medical Director or other clinical peer reviewer for determination. Licensed physicians will determine whether services are not medically necessary and/or are experimental/ investigational.

Concurrent Review

The Health Plan's medical management staff conducts concurrent review to monitor the medical necessity of an episode of care during the course of treatment. The Health Plan conducts these reviews either on-site or through telephone care management. Concurrent review is performed for inpatient as well as outpatient care. Cases not meeting criteria or requiring further evaluation are referred to a Medical Director or other clinical peer reviewer for determination. Licensed physicians determine whether services are not medically necessary and/or are experimental/investigational.

Post-Service Review

Post-service review is the detailed analysis of an episode of care after the care has been rendered. Post-service review can encompass both inpatient and outpatient services. The Health Plan's medical management staff conducts post-service review to:

- Determine whether the service is covered under the contract in force at the time services are rendered;

- Determine the medical necessity of the services utilizing clinical criteria;
- Determine appropriateness of the level of service and provider of service; and
- Identify and refer potential quality of care issues to the Quality Management Department.

Cases not meeting criteria or requiring further evaluation are referred to a Medical Director or other clinical peer reviewer for determination. Licensed physicians determine whether services are not medically necessary and/or are experimental/investigational.

Reconsiderations

Providers can call or write the Health Plan to request a reconsideration of an adverse determination when the determination involves a review in which the provider recommended the service but the Health Plan made no attempt to discuss the decision. The reconsideration for pre-service or concurrent reviews will take place within one business day of the request. Reconsiderations for post-service reviews will be completed within 30 days of the date of the request. Reconsideration decisions will be made by the same clinical peer reviewer who made the original determination.

Medical Claim Review

The purpose of medical claim review is to analyze whether a claim reflects services rendered, and to verify that the services rendered are appropriate to the clinical variables of each case, based on the standards of medical care, subscriber contract benefits and terms of participating provider agreements. This review includes:

- Reviewing supporting documentation;
- Adhering to quality of care standards;
- Reviewing potential fraud and/or abuse cases, which are referred to the Health Plan's Special Investigations Unit;
- Evaluating over- or under-utilization of services;
- Conducting or assisting with the conducting of special studies such as the Health Plan Employer Data and Information Set (HEDIS®), as designed or recommended by the Quality Management Department; and
- Referring cases to Case Management and Quality Management as needed.

4.1.3 Utilization Review Decision and Notification Time Frames

The Health Plan has established time frames for utilization review that meet state and federal regulations and accreditation standards. Notification to the member and the provider(s) is made in writing and/or by telephone. Specific time frames and notification requirements for the different types of review are presented in the chart, *Utilization Review Time Frames*, available from the Provider page of the Health Plan's Web site, or from Provider Service.
https://www.excellusbcbs.com/providers/administration/forms_for_providers.shtml

Note: Once the Health Plan has all the information necessary to make a pre-service determination, the Health Plan's failure to make a utilization review determination within the applicable time frame shall be deemed an adverse determination subject to appeal. For appeal information, see the paragraphs under *Utilization Review Appeals and Grievances* later in this Section 4.

4.1.4 Notice of Adverse Determination

An adverse determination is a determination made by the Health Plan or its utilization review agent that, based on the information provided, the preauthorization, admission, extension of stay, level of care, or other health care service is not medically necessary or is experimental/investigational and thus not covered. Time frames for notification are included in the chart, *Utilization Review Time Frames*, referenced above.

All notices of adverse determination will include:

- The clinical rationale for the denial, including a reference to the criteria on which the denial was based;
- Instructions for appealing the determination, including the expedited appeal process;
- An explanation of the right to external appeal of final adverse determinations;
- Instructions for obtaining a copy of the clinical criteria used in making the determination;
- The availability of the reviewer to discuss the denial;
- Instructions for contacting the Medical Director.

If a member disagrees with a utilization review decision, or if the Health Plan does not make the decision within the specified time frame, the member can request an internal appeal or an expedited appeal. The Health Plan has consistent procedures for responding to requests for appeals of adverse determinations made by a member, the member's authorized designee or a provider. See the paragraphs under *Utilization Review Appeals and Grievances* later in this Section 4.

4.2 Medical Policies and Protocols

The Health Plan establishes and uses medical policies and protocols as a guide for determining medical necessity. Medical policies are based on scientific evidence related to medical technology, while medical protocols clarify coverage of services based on interpretation of member contracts.

Text of all policies and protocols currently in effect are available on the Health Plan's Web site, along with an overview of the Medical Policy/Medical Protocol Development and Implementation Process. Copies of the overview and of specific protocols and policies may also be obtained upon request from Provider Service. In addition, highlights of new and revised policies and protocols are included in the monthly provider newsletter. Questions and comments may be directed to the Medical Policy Coordinator. (For Health Plan address and phone numbers, see the *Contact List* in Section 2 of this manual.)

Provider Participation in Medical Policy Development

The Health Plan Medical Policy Committee meets monthly to discuss and approve medical policies. The Health Plan encourages participating physicians to become involved in medical policy development, as follows:

- Participate in the Medical Policy Committee. For information about how to do so, contact the Regional Medical Director (see *Contact List*).
- Become involved in medical policy development. Each month, the Health Plan posts draft medical policies in the Provider section of the Health Plan Web site for participating providers' review and comment.

From the Provider page, select *Medical Policies*. From the menu on the left, select *Preview & Comment on Draft Policies*.

https://www.excellusbcbs.com/providers/patient_care/medical_policies/draft_policies/draft_medical_policies.shtml

4.3 Primary Care Physicians and Specialists *(Managed Care Only)*

The Health Plan requires a member covered by a managed care health benefit program to select a primary care physician (PCP) as a condition of his/her membership.

A member's PCP is responsible for monitoring and coordinating the health care the member receives. This may occur either by direct provision of primary care services or through appropriate referrals or preauthorizations that allow the member to receive health care services from other physician specialists and providers when medically necessary. (Referrals and preauthorizations are described later in this Section 4.)

4.3.1 PCP Responsibilities

Primary care physicians include doctors specializing in internal medicine, family practice, and pediatrics. In certain situations, a member may select a specialty physician as a PCP. These situations are described later, in the paragraph headed *Use of a Specialist as PCP*.

Primary care physicians:

- Provide all routine and preventive care.
- Refer or preauthorize members to obtain:
  - Care from participating physicians and other health professionals.
  - Laboratory tests, x-rays, and diagnostic tests.
  - Inpatient care and treatment.
  - Outpatient care and treatment.
- Work with specialty physicians and other providers for continuity and coordination of care.

A member's PCP—not the PCP's office staff—is ultimately responsible for authorizing all referrals for that member. (See the paragraphs under the heading *Referrals*.) PCPs are also responsible for obtaining all consultation reports, lab tests and test results, and to review and note the results in the medical record and document the treatment plan.

4.3.2 Specialist Responsibilities

A specialist provides services to a member of a Health Plan managed care program for a particular illness or injury, usually upon referral from the member's PCP. A participating specialist is responsible for rendering services to a member as ordered by the PCP and/or reported on a referral form.

Participating specialists must adhere to Health Plan policies and procedures regarding preauthorization requirements for hospital admissions, home health care, durable medical equipment, and other specified medical care and procedures.

Should the specialist determine that the member requires services or care in addition to those specified by the PCP or beyond the scope of the referral, the specialist must obtain another referral from the PCP, unless a standing referral has been approved. In addition, there are other exceptions where a provider other than the PCP may refer. These are described later in this Section 4.

4.3.3 Use of a Specialist as PCP

A member with a life-threatening or degenerative and disabling condition or disease that requires prolonged specialized medical care may receive a referral to a specialist who shall be responsible for and capable of providing and coordinating the member's primary and specialty care. Such referrals shall be made pursuant to a treatment plan approved by the Health Plan, in consultation with the primary care physician and the specialist, and the member. In no event shall the Health Plan be required to permit a member to elect to have a non-participating specialist as a PCP, unless there is no specialist in the network.

4.4 Referrals *(Managed Care Only)*

When a managed care member requires selected specialty services that his or her PCP cannot furnish, the PCP "refers" the member to a participating Health Plan specialist. *(The Health Plan also allows participating OB/GYNs to make any referral that a PCP can make.)* The PCP must request a referral authorization and obtain an authorization number before the specialist provides services to the member.

4.4.1 Who Can Request a Referral?

Only the member's PCP, participating OB/GYN or a participating on-call physician may generate or update referrals. There are some exceptions to this. See the chart *Who Can Generate Referrals?* It is available from the Provider page) on the Health Plan's Web site (under *Forms and Templates*, or from Provider Service.
https://www.excellusbcbs.com/download/files/who_can_generate_referrals_rochester.pdf

4.4.2 What Services Require a Referral?

Many specialty services provided outside of the PCP's office require a referral. For general referral requirements associated with a specific health benefit package, refer to the *Referral Requirements Comparison* chart available from the Provider page of the Health Plan's Web site (see Referral Guidelines) or from Provider Service.
https://www.excellusbcbs.com/providers/administration/tools_for_your_office/referral_guidelines.shtml

To determine the eligibility of a specific member, inquire through one of the Health Plan's member eligibility inquiry systems explained in Section 2 of this manual.

> **Note:** The Health Plan makes coverage decisions based upon the presence of a referral, the terms of a member's contract, and medical necessity. The presence of a valid referral does not guarantee coverage if the services provided do not meet the contractual requirements for coverage.

4.4.3 If the Member Self-refers

On occasion, a member may seek specialty services that require a referral without first contacting his/her PCP. In those instances, the Health Plan may deny benefits for HMO members for the services rendered.

Providers must inform patients *prior to the treatment* that they will be liable for the payment of these services. A **participating** specialist cannot bill an HMO member for unpaid services if those services were provided without a valid referral number, unless the member has signed a *Payment Authorization Agreement*. **Participating** specialists who elect to see a Health Plan HMO member who does not have a valid referral may wish to have the member complete and sign a *Payment Authorization Agreement.* This is described in Section 2 of this manual.

Claims for members with point-of-service (POS) health benefit programs may be eligible for coverage under the member's out-of-network benefit, but may pay at a lower level. In such case, the care provided must be medically necessary, and the member will be responsible for deductibles, coinsurance and any additional costs in excess of allowable charges.

Most other members do not need a referral for specialty services, but they may need prior authorization for selected services.

4.4.4 Standing Referrals

If the Health Plan, or the primary care physician in consultation with the medical director of the Health Plan and the participating specialist, determines that a standing referral is appropriate for a member who requires ongoing care, the Health Plan will make such a referral to a specialist.

The referral must be made pursuant to a treatment plan approved by the Health Plan in consultation with the primary care physician and the specialist. The treatment plan may limit the number of visits and the period during which treatment is authorized. The specialist shall provide regular reports to the member's PCP regarding patient care and status. In no event shall the Health Plan be required to

permit a member to elect to have a non-participating specialist, unless there is no specialist in the network.

4.4.5 Out-of-Network Referrals *(Managed Care Only)*

> **Note:** The Health Plan has established policies that, under certain circumstances, allow a member to continue to receive care from a non-participating provider if the member is new to the Health Plan, if the member's provider leaves the network and the member is receiving ongoing care or if the member is in the second or third trimester of pregnancy.

If the Health Plan's panel of providers does not include a health care provider with the appropriate training and experience to meet a member's particular health care needs, the member's PCP must submit a letter of medical necessity to request service from an out-of-network provider. The Health Plan may grant a referral pursuant to a treatment plan approved by the Health Plan's medical staff in consultation with the primary care physician, the non-participating provider and the member.

In such event, the Health Plan will arrange for the covered services to be provided at no additional cost to the member beyond what the member would otherwise pay for services received within the Health Plan's provider network. In no event shall the Health Plan be required to permit a member to elect to have a non-participating specialist except as approved above.

Referrals to Specialty Care Centers

A member with a life-threatening or a degenerative and disabling condition or disease that requires specialized medical care over a prolonged period of time may receive a referral to an accredited or designated specialty care center with expertise in treating the life-threatening or degenerative and disabling disease or condition.

In no event shall the Health Plan be required to permit a member to elect to use a non-participating specialty care center unless the Health Plan does not have within the network an appropriate specialty care center to treat the member's disease or condition. Services shall be provided pursuant to the approved treatment plan and at no additional cost to the member beyond what the member would otherwise pay for services received within network.

4.4.6 How to Request a Referral

Information Needed to Generate a Referral

1. Member ID number
2. Name of referral specialist
3. Number of visits requested
4. Time period
5. Diagnosis
6. Date of service

When to Generate or Update Referrals

Referrals must be generated and authorized by the Health Plan *prior* to the patient's visit to the specialist. On certain occasions subject to review, a retroactive referral may be allowed, providing the patient did not self-refer. To request consideration for a retroactive referral, call Managed Care Provider Services.

Methods PCPs Can Use to Generate and Update Referrals

With the exception of the services listed on the previous pages, only the patient's PCP, alternate Ob/Gyn PCP, or on-call physician may generate referrals or admissions. Health care providers who are not the patient's PCP must call Provider Services to generate referrals or admissions.

InfoCheck (Automated Telephone System)

PCPs can use InfoCheck to enter or update patient referrals and admissions. Call InfoCheck (see *Contact List* in Section 2 for numbers) using a touch-tone telephone. Follow the voiced instructions. You'll need your Personal Identification Number (PIN), a number we require to ensure security, and the provider ID number of the referral specialist. If you don't know your PIN, call Managed Care Provider Services.

QuickLink (Electronic System)

Using their computer, PCPs can access Health Plan files directly to enter or update patient referrals and admissions. Call Trading Partner Support at the number listed on the *Contact List* in Section 2 for information on connecting to QuickLink.

Facsimile

Faxing referrals is easy for PCPs using the Specialist Referral Form at the end of this section. The fax number is on the form. The form is also available on the Web site or from Provider Service. https://www.excellusbcbs.com/download/forms/referral_form_rochester.pdf

Provider Services

PCPs and specialists may also contact our Managed Care Provider Services Department to generate or update patient referrals. Telephone numbers are included on the *Contact List* in Section 2 of this manual.

Out-of-area referrals require the following additional information:

- Complete address, phone number and specialty of treating provider
- Reason member is out-of-area
- Name of referring physician
- Patient's diagnosis/urgency of visit
- Date of service

If a request for referral is approved, the Health Plan will send written confirmation of the referral request to the requesting physician, the referral specialist (or facility) and to the member. If the referral

is denied, the Health Plan will send written notification of the denial to the member and the ordering physician. The notification will explain the reason for the denial – including the specific utilization review criteria or benefit provisions used in making the determination – and information about the appeal process. Notice is not given to the referred to specialist (due to HIPAA privacy regulations).

4.5 Preauthorization

The Health Plan requires that it review certain services in advance to determine if the services are medically necessary, appropriate for the specific member, and experimental and/or investigational. Before providing these services, a provider must request authorization from the Health Plan, which initiates the review.

The Health Plan will deny claims for services that require preauthorization but were not preauthorized. For information on appeals, see the paragraphs under *Utilization Review Appeals and Grievances*.

If a request for preauthorization is approved, the Health Plan will generate written confirmation and will send a copy to the requesting physician, the referred to specialist (or facility) and to the member. If the authorization is denied, the Health Plan will send written notification of the denial to the member and the ordering physician. The notification will explain the reason for the denial – including the specific utilization review criteria or benefit provisions used in making the determination – and information about the appeal process. Notice is not given to the referred to specialist or facility (due to HIPAA privacy regulations).

The Health Plan makes coverage decisions based upon the presence of an authorization, the terms of a member's contract and medical necessity. The presence of an authorization does not guarantee coverage if the services provided do not meet the contractual requirements for coverage.

4.5.1 Who Can Request a Preauthorization?

In managed care plans, only the member's PCP or a specialist with a valid referral from the PCP may request the required preauthorization. (For exceptions, see the chart *Who Can Generate a Referral?* available on the Health Plan's Web site or from Provider Service.
https://www.excellusbcbs.com/download/files/who_can_generate_referrals_rochester.pdf

In other plans, the member's PCP or the treating provider may request preauthorization.

4.5.2 What Services Require Preauthorization?

Services are subject to preauthorization based on the individual member's contract. See the Prior Authorization Requirements Comparison chart, available on the Health Plan Web site or from Provider Service, for preauthorization requirements for most managed care health benefit programs.
https://www.excellusbcbs.com/providers/online_services/referrals/referral_guidelines.shtml

Prior authorization requirements for non-managed care health benefit programs may be listed on the member's ID card.

To determine the benefit requirements for a specific member, inquire through one of the Health Plan's member eligibility inquiry systems explained in Section 2 of this manual.

4.5.3 Reversal of Preauthorized Service

Under New York State law, a managed care organization (MCO) may reverse approval of a preauthorized treatment, service or procedure when:

- The relevant medical information presented to the MCO or utilization review agent upon retrospective review is materially different from the information that was presented during the preauthorization review; and
- The relevant medical information presented to the MCO or utilization review agent upon retrospective review existed at the time of the preauthorization but was withheld from or not made available to the managed care organization or utilization review agent; and
- The MCO or utilization review agent was not aware of the existence of the information at the time of the preauthorization review; and
- Had the MCO or utilization review agent been aware of the information, the treatment, service, or procedure being requested would not have been authorized. This determination is to be made using the same standards, criteria or procedures as used during the preauthorization review.

4.5.4 Preauthorization for Physical Therapy and/or Occupational Therapy

Providers requesting preauthorization for physical and/or occupational therapy follow the same process as for most other services requiring preauthorization with the following exceptions:

- The request is for additional visits.
- The request is for a different diagnosis or to see a different practitioner.

Additional Visits

If the physical or occupational therapist feels that more visits are warranted, he or she should request them prior to the last authorized visit, using the *PT/OT Patient Progress Report* form. This form is available on the Health Plan's Web site, or from the Medical Intake representative. The *Patient Progress Report* form may be completed by the physical or occupational therapist and faxed to the fax number on the form.
https://www.excellusbcbs.com/download/forms/pt_ot_progress_report_form.pdf

If the Health Plan determines that the request for additional visits does not meet the Health Plan criteria, the Health Plan will ask the physical therapist or occupational therapist to send all case note documentation, including objective, measurable data and an updated physician order. The Health Plan will review patient progress over the previous two-week interval. The case will be presented to a Health Plan Medical Director for review. The Medical Director may authorize additional visits or deny coverage for further services.

If treatment is denied, the member or his/her representative may initiate an appeal of this decision. See the paragraphs headed *Utilization Review Appeals and Grievances* later in this Section 4 for information about appeals.

New Course of Treatment – Same Year

If a physical therapist or occupational therapist requests another authorization while an earlier authorization is still active (due to a different diagnosis or a different practitioner), the Health Plan requires completion of a *PT or OT Initial Authorization Form*. When the provider calls for the authorization, if the representative finds an authorization still open, he/she will request that the provider complete a *PT or OT Initial Authorization Form*. This form is available on the Health Plan's Web site, or from Provider Service.
https://www.excellusbcbs.com/download/forms/pt_ot_initial_auth_form.pdf

4.5.5 Medical Specialty Medication Review Program

Medical specialty drugs covered under a member's medical benefit, instead of a prescription drug benefit are typically administered by a health care provider in the office, at an infusion center, at an outpatient facility or in some cases, by home care agency employees or otherwise via home infusion. *(Drugs covered under a member's prescription drug benefit are typically those drugs that can be self-administered.)*

Preauthorization for those drugs covered under a member's medical benefit and that require preauthorization is handled through the Medical Specialty Medication Review Program. Refer to Section 5 of this manual for discussion of medical specialty drugs and the Medical Specialty Medication Review Program.

4.6 Emergency Care Services (In-Area and Out-of-Area)

A referral is not required for treatment of an emergency medical condition in an emergency room. An **emergency medical condition** is defined as a behavioral or medical condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of medicine and health could reasonably expect the absence of immediate medical attention to result in placing the health of the person afflicted with such a condition in serious jeopardy, or in the case of a behavioral condition, placing the health of the person or others in serious jeopardy, or serious impairment to such person's bodily function or serious dysfunction of any bodily organ or part of such person or serious disfigurement of such person.

4.7 Inpatient Admissions

Many of the Health Plan's health benefit programs require prior authorization for inpatient admissions. Some health benefit programs do not include a benefit for skilled nursing facilities, inpatient acute rehabilitation, inpatient mental health or inpatient chemical dependency services. It is important that providers verify eligibility for non-emergency inpatient admissions prior to admitting.

For those health benefit programs that do not require prior authorization for inpatient admission, the

Health Plan encourages the admitting physician to notify the Health Plan before admitting a member for inpatient care, or within 48 hours of admitting a member for emergency care.

The Health Plan will deny claims for services that require preauthorization but that were not preauthorized. For information on appeals, see the paragraphs following the heading *Utilization Review Appeals and Grievances*.

4.8 Site of Service: Inpatient versus Outpatient

Several national standards indicate that many surgical procedures are most appropriately rendered in an outpatient setting, either the outpatient department of a hospital, a freestanding ambulatory surgery center, an observation level of care or a physician's office. The Health Plan has established a list of these procedures. See the *Outpatient Procedure List* available on the Health Plan's Web site or from Provider Service.
https://www.excellusbcbs.com/providers/online_services/referrals/outpatient_procedure_list.shtml

Except in special circumstances, these procedures will be covered only when performed in an outpatient setting. **Any facility or individual provider who feels that the patient has a special medical condition or complication that requires an inpatient stay for a listed procedure should contact the Health Plan for authorization prior to scheduling the procedure**.

If this authorization is not obtained in advance, the surgeon will be paid for the surgical services provided, but the facility will be denied payment.

If the patient is already hospitalized and requires a surgical procedure that is on the outpatient procedure list, the procedure is covered as part of the inpatient stay if it is deemed medically necessary that the patient remain hospitalized.

4.9 Care Coordination

One aspect of the Health Plan's utilization management function is to coordinate the care of hospitalized members who are enrolled in specific health benefit programs. The goal is to not only ensure that the member receives the appropriate level of care while in the hospital, but also to facilitate a smooth transition to appropriate post-discharge services such as home care and case and disease management programs.

Health Plan staff works with hospital case managers and discharge planners while the member is hospitalized. While hospital medical staff remains responsible for all medical care and treatment decisions, Health Plan staff is available to make timely referral into health plan services and programs that could benefit the patient after discharge, or while still hospitalized.

4.10 Case Management

NOTE: *Applies to all products, except when changed by a member's contract.*

4.10.1 General Policies and Procedures

Case Management is a program that assists members with a complex, chronic illness or behavioral health condition to maintain or improve their health and quality of life. Case managers provide a means to achieve member wellness and autonomy through support of the physician's treatment plan, advocacy, communication, education, coordination of service resources, and facilitation of solutions. Case managers do this by collaborating directly or indirectly with physicians, specialists, community resources, and internal resources on behalf of members and their families.

The Health Plan provides case management services at no additional cost to members whose contract supports case management, and who meet the qualifying criteria stated in the contract. Members may benefit from education, preventive care and intense management of acute needs that could vary by intensity levels. Case management is designed for members who have one of the following illnesses or health care needs:

- Chronic illness (an illness that has persisted for a long period of time and is expected to continue);
- Complex illness (an acute or prolonged illness usually considered to be life-threatening or with possible serious residual disability);
- Behavioral health illness (both psychological and substance abuse disorders);
- Need for organ transplantation, solid or bone marrow (also see paragraphs on *Medically Complex Transplantation Case Management Program* later in this Section 4);
- Other diseases such as diabetes, coronary artery disease, asthma and heart failure, or
- Other medical or psychosocial needs that may be positively influenced by case management.

Policies

- Members who may benefit from case management are identified by the member's primary care physician or through risk assessment or another internal mechanism.
- The Plan of Care is developed in collaboration with the member, the member's physician, an RN case manager, a medical social worker, and specialty care physicians, as appropriate.
- Members meet defined discharge criteria before case closure is considered.
- Preauthorization is required for all solid organ and bone marrow transplants.

Procedures

1. The Health Plan's Case Management Department has established criteria for identifying individuals who may appropriately be considered for case management services. These criteria are available upon request from Provider Service.

   Physicians also may refer a member to the Case Management Program by calling Case Management (see *Contact List* in Section 2) and providing the following information:
   - Member's name and ID number
   - Referring physician's name and Health Plan provider ID number
   - Primary diagnosis
   - Facility (if any) where patient is located
   - Anticipated case management needs
   - Anticipated services required

2. Once the member is identified, a case manager contacts the member to disclose specific information about the proposed case management services and ensures the member's willingness to participate. Using standard telephone assessment tools, the case manager assesses the member's needs and determines the acuity and intensity of case management services required.
3. With the member and physician's participation, the case manager develops an individual Plan of Care that supports the physician's treatment plan. The Plan of Care specifies goals to be met, planned interventions, frequency of follow-up care and discharge criteria.
4. The Plan of Care is implemented and regularly evaluated for effectiveness towards goal attainment.
5. The case manager follows Health Plan policy to determine when a member is appropriate for discharge from case management. Discharge criteria are explained to the member during case closure, and the physician is notified.
6. The Health Plan conducts quality reviews of cases to ascertain, among other criteria, the appropriateness and effectiveness of services provided, the timeliness of follow-up, and staff compliance with case management standards.

4.10.2 Medically Complex Transplantation Case Management Program

NOTE: *Applies to all products, except when changed by a member's contract.*

The Health Plan's Medically Complex Transplant Case Management Program is designed to assist in the coordination of member care throughout the transplantation process. The program focuses on transplantation of bone marrow and these solid organs: pancreas (SKP/PAK/PAS), lung, heart, heart/lung, liver, kidney and intestine.

NOTE: Transplantation services may require preauthorization.

Case managers investigate all members who are identified as needing, or having obtained, a solid organ transplant (other than a kidney) or bone marrow transplant. A transplant case managers assists a member in need of a kidney transplant only if the member, as a result of complications, meets case management criteria. Once an eligible member has been identified, case managers follow the procedures described in the preceding paragraphs.

4.10.3 For Children: CompassionNet

CompassionNet is a case management program offered by the Health Plan for children with potentially life-threatening illnesses and their families. The goal of CompassionNet is to provide supports necessary for the family to continue functioning as normally as possible through a tremendously stressful situation.

Policies

- CompassionNet coordinates the delivery of necessary social and support services with the medical care needed by children diagnosed with potentially life-threatening illness and their families. CompassionNet does not provide primary care.

  Some of the services CompassionNet may arrange are:
  - Outpatient care
  - Home health care
  - Referrals to community-based care and support services
  - Respite care
  - Palliative care consultation
  - Equipment/DME/supplies
  - Spiritual support
  - Counseling to patient and family, including bereavement care
- CompassionNet is open to all Health Plan members who are children.
- Children who have a chronic illness without complications and who are expected to live to adulthood are ineligible for this program.
- CompassionNet, in the discretion of the Health Plan, makes available interdisciplinary and complementary services from the time of diagnosis through the course of illness, as needed.
- A CompassionNet case manager may approve concurrent curative and palliative treatments.
- Families may be asked to participate in the cost of optional non-therapeutic services as determined by a sliding scale.

Procedures

To refer a Health Plan member to CompassionNet, the provider treating the child must call CompassionNet. (See the *Contact List* in Section 2 of this manual.)

4.11 Disease Management

The Health Plan has established a disease management program designed to assist eligible members living with chronic illness to better manage and control their disease. Through the disease management program, members may receive disease-specific mailings, access Web-based education, utilize self-care resources, and participate in telephonic education. Eligible members may also participate in health coaching.

4.11.1 Care Calls

Care Calls is a "reach and teach" program that supports eligible Health Plan members with chronic illnesses, including diabetes, heart failure, CAD, asthma and depression.

Care Calls was designed and is directed by physicians. The goal of the program is to improve the self-management skills of members with chronic illnesses through a series of scheduled telephone calls from a Registered Nurse trained in the management of patients with chronic illnesses.

The program emphasizes member education, self-management and self-monitoring skills, and support for a member's efforts towards lifestyle change.

Program benefits include:

- An alternative to, or a support for, classes or group sessions.
- Free educational packets and self-monitoring tools.
- Individual instruction and coaching by telephone through a series of scheduled contacts based on a standard curriculum.
- Flexible service hours to meet the member's needs.
- Encouragement to adhere to physician's treatment recommendations regarding medication, physical activity, nutrition and self-monitoring.
- Links to available community services.

To contact *Care Calls*, see the *Contact List* in Section 2 of this manual.

4.11.2 Health Coaching

This program, available only to eligible members, offers health coaching, educational materials and decision support for individuals with chronic conditions such as heart disease, asthma, diabetes, back pain, uterine bleeding, prostate cancer and many others.

The Health Coaching Program provides eligible members with 24-hour daily telephone access to nurses, dietitians and respiratory therapists. These health coaches provide unbiased, evidence-based health information. The goal is to help patients work with their physicians to improve self-management and decision-making skills. Health Coaching also gives patients 24-hour daily online access to an encyclopedia of health information.

4.12 Health Promotion

The Health Promotion Department offers self-serve and high touch programs and services to Health Plan members in order to enhance early identification and intervention of preventable conditions, encourage healthy behaviors and improve self-care and informed decision making. The Health Plan uses a variety of delivery methods (such as face-to-face, online, telephone and print) to deliver the programs described below.

4.12.1 Health Risk Assessment

A Health Risk Assessment is a questionnaire that asks about lifestyle, diet habits and medical history. Adult members complete this questionnaire on the Internet. It takes less than 15 minutes. The participant receives a *Personal Wellness Report* immediately after completing his/her Health Risk Assessment. This report recommends actions the participants can take to protect and improve their health. It highlights areas where the participant may already be doing well, provides ideas for healthy living and for minimizing risks of being sick or injured in the future. It also provides access to programs the member can select such as the online Healthy Living Programs, tobacco cessation and Health Coaching.

The Health Plan member can then select a program that will help him or her improve areas identified in the Personal Wellness Report, such as one of the Health Living Programs or the Quit for Life tobacco cessation program. Eligible patients can access the Health Risk Assessment on the Health Plan's Web site.

4.12.2 Risk Reduction Programs

Healthy Living Programs

The Healthy Living Programs are comprehensive online programs that can help participants achieve their health objectives in a fun, interactive manner. Participants will also benefit from a wealth of interactive tools and services such as:

- Reminder e-mails to keep participants motivated.
- Healthy and delicious seven-day meal plans tailored to the participant's preferences.
- Calorie, fat and heart calculators.
- Virtual trainers to create exercise routines and demonstrate proper technique.
- Build-a-plate to illustrate the nutritional value of a meal based on food selections.

Quit for Life℠ Program

Quit for Life is a scientifically based tobacco cessation program established on 20 years of published research and clinical experience. When your patients who are eligible Health Plan members enroll in the Quit for Life Program they will receive:

- Telephone sessions scheduled at their convenience.
- Unlimited toll-free telephone access to a Quit Coach.
- Recommendations on medication type, dose, and duration, where appropriate.

- Fulfillment of nicotine replacement therapy (such as the patch or gum).
- A Quit Kit of materials designed to help your patient stay on track between calls.

Eligible members can access the Healthy Living Programs on the Health Plan's Web site. Your patients who are interested in learning more about quitting tobacco can call the Quit for Life Program at the Quit for Life number in the Contact List in Section 2 of this manual. If they are not eligible for the program, they will be transferred to the NYS Quitline for assistance.

4.12.3 Step Up Program

Step Up is a program available to **all** Health Plan members.

Step Up makes losing weight and staying healthy easier. It's designed to help individuals take small steps every day towards reaching goals, like walking a little bit more and eating a little bit smarter. Step Up is based on recommended goals of taking 10,000 steps and eating five servings of fruits and vegetables every day.

Registered users can set goals and monitor their improvement using their personal progress tracker. They also have access to tools, resources and literature on physical activity and nutrition. Regardless of your patients' age or fitness level, Step Up has something to help everyone live a healthier lifestyle.

Your patients can access the Step Up program at stepup.excellusbcbs.com. To print or order valuable Step Up resources for your office such as BMI charts, Resource Sheets, Balance Books and Rx Pads, go to the Web site listed above and select Providers on the top navigation bar.

4.12.4 Decision Support Tools

NOTE: The following tools are available to all Health Plan members.

Healthwise®

Healthwise is an online database containing evidence-based content on over 5000 topics. The database provides insight on questions regarding health conditions, medical tests, procedures, medications and everyday health and wellness. Healthwise has a "decision point" feature that helps individuals understand their options and provides information to help them make wise decisions. There are seven opportunities to use Healthwise including:

- Self care
- Self triage
- Provider visit preparation
- Self management of chronic conditions
- Shared decision making
- End-of-life care

Click and Compare Care

Click and Compare Care allows members to create a customized report to compare hospital performance for more than 175 procedures and medical conditions. The report shows the number of

patients treated at each hospital, the percentage who developed problems, the percentage who died, the average length of stay, and the average price charged by the hospital. These reports are based on information hospitals provide to Medicare and their state's health departments or other local agencies.

Your patients can access Healthwise and Click and Compare Care on the Health Plan's Web site. Both programs are located under *Health and Wellness*.
https://www.excellusbcbs.com/members/health_and_wellness/index.shtml

4.12.5 Worksite Wellness

The Health Plan's Worksite Wellness Services are designed to enhance our care coordination approach while motivating members to become more knowledgeable health care consumers. Services are coordinated through employers and accessed by members at their worksites. Services include:

Preventive Health Screenings

All health screening participants receive lifestyle counseling which includes feedback about their results and what, if any, actions they need to take. Those members with abnormal results are sent a follow-up letter reminding them to follow up with their primary care physicians. Members also receive educational materials and are connected to the Health Plan's Excel for Life health and medical programs and services.

The following screenings can be provided:

- Blood pressure
- Blood glucose
- Body mass index (BMI)
- Total cholesterol
- Lipid profile

Health Education Programs

More than 20 education programs are offered covering a wide selection of topics to promote healthier lifestyles. These topics are offered in either a one-hour format or a more comprehensive approach delivered through multiple sessions.

4.12.6 Member Rewards Program

The Health Plan has established a Member Rewards Program that connects members to health resources right in their neighborhoods. Members can learn about such topics as healthy cooking, managing stress, or controlling weight. They can also get help getting started on an exercise program. There are discounts on many services including, but not limited to, massage therapy, biofeedback, and health club memberships.

The Member Rewards catalog is available online at the Health Plan's Web site, or upon request from Provider Service or Customer Service.

4.13 Utilization Review Appeals and Grievances

NOTE: The following procedures do not apply to Medicare Advantage programs. For appeals and grievance procedures available to members of Medicare Advantage health benefit programs, see Section 10 of this manual.

The following paragraphs describe:

- The handling of appeals that involve a medical necessity determination (see paragraphs headed *Internal Appeals* and *External Appeals*).
- The review of issues (including quality of care and access to care complaints) not associated with medical necessity or experimental and/or investigational determination, excluding service requests (see paragraphs headed *First-level Grievance* and *Second-level Grievance*).

This process is intended to provide a reasonable opportunity for a full and fair review of an adverse determination.

4.13.1 General Policies

- **Assistance of a designee.** A member may designate a representative (including a lawyer or health care provider) to act on his or her behalf at any stage of the appeal or grievance process. The designation must be in writing. For the purpose of this policy, any reference to member includes a member's designated representative if the member has chosen one.
- **Internal Appeal**. If a member is not satisfied with a medical necessity determination or an experimental and/or investigational determination of the Health Plan, the member may submit an internal appeal. All requirements pertaining to internal appeals are described below.
- **Expedited Internal Appeal.** Cases involving the following are subject to an expedited internal appeal:
  - Requests for review of continued or extended health care services;
  - Requests for additional services in a course of continued treatment; or
  - Cases (other than retrospective review cases) in which a provider requests an immediate review.
- **External Appeal.** If a member is not satisfied with an internal appeal determination (the "final adverse determination" for purposes of external appeal), the member may submit a request to the New York State Insurance Department for an external appeal. All requirements pertaining to external appeal are described below.
- **Level One Grievance.** If a member is not satisfied with a determination made by or on behalf of the Health Plan that does not involve a medical necessity determination or an experimental and/or investigational determination, the member may submit a Level One grievance. This is the only level of grievance review available to members enrolled under non-managed care contracts. All requirements pertaining to Level One grievance review are described below.

- **Level Two Grievance.** If a member who is enrolled under a managed care contract is not satisfied with a Level One grievance determination, the member may submit a Level Two grievance. All requirements pertaining to Level Two grievance reviews are described below.
- **No Retaliation.** The Health Plan will not retaliate or take any discriminatory action against a member because the member requested an internal or external appeal.
- **Legal Action.** The levels of appeal/grievance below should be exhausted before a member can bring legal action against the Health Plan.
- **Automatic Reversal.** The Health Plan's failure to render a determination on a *standard appeal* within 60 calendar days results in a reversal of the initial adverse determination. Failure to render a determination on an *expedited appeal* within two business days from receipt of all information will result in a reversal of the initial adverse determination.

4.13.2 The Appeal/Grievance Process

Policies

Members have the right to request the identification of all experts whose advice the Health Plan obtained in connection with an adverse determination. In addition, if the Health Plan upholds a claim denial on appeal, members have the right to request, free of charge, copies of all documents and other information relevant to the Health Plan's claim determination. All appeals are thoroughly documented and investigated.

Procedure

1. The member and, in post-service (retrospective) review cases, the member's health care provider, may request an internal appeal of an adverse determination, either by phone, in person or in writing.
   - The member may make a verbal request by calling the phone number listed on his/her identification card. Written appeal requests can be submitted to the address of the Health Plan listed on the member's identification card.
   - The member has up to 180 calendar days from receipt of the notice of adverse determination to file an appeal.
   - The member, the member's health care provider or the member's designated representative has the right to submit written comments, documents or other information in support of the appeal.

2. The Health Plan will acknowledge the request for an appeal within 15 calendar days of receipt of the appeal. The acknowledgment will include the name, address and phone number of the person handling the appeal. If necessary, it will inform the member—and in post-service (retrospective) review cases, the member's health care provider—of any additional information needed before a decision can be made.

3. In cases where additional information is deemed necessary, the following guidelines will apply.

a. Standard Appeals

- The Health Plan will send a letter to the member and his/her provider requesting and identifying the additional information needed. The Health Plan will send this letter within the applicable case time period but no later than 15 calendar days of receipt of the request for appeal.
- If, subsequently, the member and/or his/her provider provide only partial information to the Health Plan, the Health Plan will send a letter *to the member and his/her provider* requesting and identifying the additional information needed. The Health Plan will send this letter within five business days of receipt of the partial information.

b. Expedited Appeals

- The Health Plan expeditiously will request and specify the additional information via phone or fax from the member and his/her provider followed by written notification to the member and provider.

4. When the Health Plan reviews a claim on appeal, it will not give any deference to the initial decision. A clinical peer reviewer who is not subordinate to the clinical peer reviewer who made the initial decision will decide the appeal.

> **NOTE:** A clinical peer reviewer is defined as a physician who possesses a current and valid non-restricted license to practice medicine or a health care professional other than a licensed physician who, where applicable, possesses a current and valid non-restricted license, certification, or registration or, where no provision for a license, certificate, or registration exists, is credentialed by the national accrediting body appropriate to the profession and is in the same profession/specialty as the health care provider who typically manages the medical condition or provides the treatment at issue.

4.13.3 Medical Necessity or Experimental/Investigational Appeals

Expedited Appeals

The Health Plan will decide appeals involving pre-service (prospective) events within the lesser of two business days or 72 hours of receipt of the appeal. Written notice will follow within 24 hours of the Health Plan's determination, but no later than 72 hours of receipt of the appeal request. If the member is not satisfied with the resolution of the expedited appeal, he/she may file a standard internal appeal or an external appeal.

The Health Plan will transmit all information relating to the appeal to the member and the member's provider, and will accept by telephone or facsimile information from the member, the member's provider or the member's designated representative relating to the appeal.

The Health Plan will handle reviews of continued or extended health care services and additional services rendered in the course of continued treatment as expedited appeals.

Pre-Service Appeals

The Health Plan will decide appeals involving pre-service (prospective) matters within 30 calendar days of receipt of the appeal request. The Health Plan will provide written notice of the determination to the member (and the member's provider if he or she requested the review) within two business days after the determination is made, but not later than 30 calendar days after receipt of the appeal request.

Post-Service Appeals

The Health Plan will decide appeals filed post-service (retrospective) within 60 calendar days of receipt of the appeal request. The Health Plan will provide written notice of the determination to the member (and the member's provider if he or she requested the review) within two business days after the determination is made, but not later than 60 calendar days after receipt of the appeal request.

Determination upon Appeal

Upon making its determination, the Health Plan will send a notice of determination of the internal appeal that will include the following information:

- A clear statement describing the basis and clinical rationale for the denial as applicable to the member;
- The titles and credentials of the appeal reviewer;
- A clear statement that the notice constitutes a final adverse determination;
- The Health Plan's contact person and his or her telephone number;
- The member's coverage type;
- The name and full address of the Health Plan's utilization review agent (which may be the Health Plan itself);
- The utilization review agent's contact person and his or her telephone number;
- A description of the health care service that was denied, including, as applicable and available, the dates of service, the name of the facility and/or provider proposed to provide the treatment and the developer/manufacturer of the health care service;
- A statement that the member may be eligible for an external appeal and the time frames for requesting an appeal (a copy of an external appeal application is sent to the member with the final adverse determination letter); and
- A clear statement written in bolded text that: the 45-day time frame for requesting an external appeal begins upon receipt of the final adverse determination of the first level appeal, regardless whether a second level appeal is requested; and that by choosing to request a second level internal appeal, the time may expire for the enrollee to request an external appeal.

The Health Plan will keep all requests and discussions confidential and no discriminatory action will be taken because the member has filed an appeal. There is a process for both standard and expedited appeals. Appeals are thoroughly reviewed and documented. The Health Plan will maintain a file on each appeal that includes the date the appeal was filed; a copy of the appeal, if written; the date upon which the acknowledgment was received, and a copy of the acknowledgment; the appeal determination, including the date of the determination; and the titles of the personnel and credentials of clinical personnel who reviewed the appeal.

4.13.4 External Appeals *[not applicable for Administrative Services Only (ASO) groups]*

A provider can request an external appeal only for post-service (retrospective) adverse determinations. A provider may **not** request an external appeal of a pre-service (prospective or concurrent) utilization review determination. A provider must use a separate request form (available upon request from the Health Plan) to request external appeal. Upon the provider's request, the Health Plan will send him/her the request form within three business days.

Procedure

1. A provider or a member may submit a request for an external appeal:
   a. The provider has 45 days from the time the provider receives the notice of the final adverse determination to submit the external appeal.

      In the event that the enrollee (member) has pursued the internal appeal process without notifying the provider, it is possible that the provider would never have received "notice" of the final adverse determination. Under such circumstances, an enrollee whose 45-day deadline had expired could revive his/her time for filing simply by "notifying" the provider of the final adverse determination and asking the provider to request the external appeal on the enrollee's behalf. To protect against this, the member may file an application as explained in *b,* below.

   b. A member may file an application for an external appeal by a state-approved external appeal agent if the member has received a denial of coverage based on medical necessity or because the service is experimental and/or investigational. To be eligible for an external appeal, the member must have received a final adverse determination as a result of the Health Plan's internal appeal process, or the Health Plan and the member must have agreed jointly to waive the internal utilization review appeal process.

2. The member or provider may obtain an external appeal application:
   - From the New York State Insurance Department at 1 (800) 400-8882, or its Web site; www.ins.state.ny.us
     or
   - By calling the Health Plan at the telephone number listed on the member's Health Plan identification card.

The application will provide clear instructions for completion. A fee of $50.00 may be required to request an external appeal. The Health Plan waives the cost to the member for filing an external appeal.

3. The application for external appeal must be made within 45 days of the member or provider's receipt of the notice of final adverse determination as a result of the Health Plan's appeal process, or within 45 days of when the Health Plan and the member and/or provider jointly agreed to waive the internal appeal process.

   The member may request an expedited external appeal if the member and/or the member's health care provider can attest that a delay in providing the recommended treatment would pose an imminent or serious threat to the member's health.

   A member will lose his/her right to an external appeal if he/she does not file an application for an external appeal within 45 days from receipt of the final adverse determination from the internal appeal.

4. The application will instruct the member to send it to the New York State Department of Insurance. The member must release all pertinent medical information concerning his/her medical condition and request for services.

5. An independent external appeal agent approved by the State will review the request to determine if the denied service is medically necessary and should be covered by the Health Plan. All external appeals are conducted by clinical peer reviewers. The agent's decision is final and binding on both the member and the Health Plan.
   - For standard appeals, the external appeal agent must make a decision within 30 days of receiving the application for external appeal from the State. Five additional business days may be added if the agent needs additional information.
   - If the agent determines that the information submitted is materially different from that considered by the Health Plan, the Health Plan will have three additional business days to reconsider or affirm its decision. The member will be notified within two business days of the agent's decision.
   - For expedited appeals, the external appeal agent will make a decision within three business days. The agent will make every reasonable effort to notify the member and the Health Plan of the decision immediately by phone or fax. This will be followed immediately by a written notice.

4.13.5 Appeals Based on any Reason other than Medical Necessity or Experimental/Investigational Denials (Grievances)

If a member is not satisfied with a determination made by or on behalf of the Health Plan that does not involve a medical necessity determination or an experimental and/or investigational determination, the member may submit a grievance.

For example, the grievance procedure would be used to resolve a dispute in which the Health Plan decided that the member does not meet the requirements for coverage of a particular service, or that an out-of-area referral was unnecessary. The grievance procedure also applies to complaints involving service quality.

Filing a First-Level Grievance

This is the only level of grievance review available to non-managed care members.

1. The member or his/her designee may file a first-level grievance either by phone, in person or in writing.
   - The member may make a verbal request by calling the phone number listed on his/her identification card. Written grievance requests can be submitted to the address of the Health Plan listed on the member's identification card.
   - A member has up to 180 calendar days from receipt of the decision to file a grievance.

2. The Health Plan will acknowledge the request for a grievance within 15 calendar days of its receipt. The acknowledgment will include the name, address and phone number of the person handling the grievance. If necessary, the acknowledgment will inform the member of any additional information needed before a decision can be made. The member may submit additional information pertinent to the grievance.

3. When the Health Plan reviews a first-level grievance, it will not give any deference to the initial decision. When a member files a first-level grievance, an individual who is not subordinate to the individual who rendered the initial determination will review the grievance. If the first-level grievance involves a clinical matter, a clinical peer reviewer will decide the first-level grievance.

   The Health Plan will keep all requests and discussions confidential and no discriminatory action will be taken because the member has filed a grievance. There is a process for both standard and urgent grievances. Grievances are thoroughly reviewed and documented. The Health Plan will maintain a file on each grievance. The file will include the date the grievance was filed; a copy of the grievance, if written; the date of receipt of and a copy of the acknowledgment; the grievance determination, including the date of the determination; and the titles of the personnel and credentials of clinical personnel who reviewed the grievance.

4. The Health Plan will make its determination.

   a. Urgent Grievances

   If a first-level grievance relates to an urgent matter, the Health Plan will decide the first-level grievance and notify the member of the determination by phone within 48 hours of receipt of the first-level grievance request. Written notice will follow within 24 hours of the Health Plan's determination.

b. Pre-Service Grievances

If a first-level grievance relates to a pre-service (prospective) matter, the Health Plan will decide the first-level grievance and notify the member of the determination in writing within 15 calendar days (for managed care products) or 30 calendar days (for products other than managed care) of receipt of the first-level grievance request.

c. Post-Service Grievances

If a first-level grievance relates to a post-service (retrospective) matter, the Health Plan will decide the first-level grievance and notify the member of the determination in writing within 30 calendar days of receipt of the first-level grievance request.

d. Intangible Level 1 Grievances

Intangible grievances include the following categories:

- *Clinical Quality of Care*. A clinical quality concern is one that may adversely affect the health and/or well being of the member. Examples of this may include perceptions of inadequate or inappropriate treatment or failure to diagnose accurately.
- *Access to Care.* Inability to obtain a timely appointment or after-hours appointment.
- *Interpersonal Issues.* Interpersonal issues with a provider or his/her office staff or other complaints against the corporation.

All intangibles must be resolved and the member notified within 45 calendar days after receipt of all information. The Health Plan will handle urgent clinical situations expeditiously. The Health Plan will notify the member of the results of an expedited review within 72 hours after receipt of all information.

5. Upon making its determination, the Health Plan will send a notice of determination of the first-level grievance that will include:
   - The name and title of the reviewer,
   - Detailed reasons for the determination, and, if the grievance involves a clinical matter,
   - The clinical rationale for the determination and information about how to file a second-level grievance, including the appropriate form.

Filing a Second-level Grievance

1. If a managed care member is not satisfied with the resolution of a first-level grievance, the member or his/her designated representative may file a second-level grievance.
   - A member has up to 180 calendar days from receipt of the first-level grievance determination to file a second-level grievance.
   - The member may file a second-level grievance by phone, in person or by writing.

2. The Health Plan will acknowledge the request for a second-level grievance within 15 calendar days of receipt. The acknowledgment will include the name, address and phone number of the person handling the grievance.

3. The Health Plan will review the second-level grievance. One or more qualified personnel at a higher level than the personnel who rendered the first-level grievance determination will decide the second-level grievance. If the second-level grievance involves a clinical matter, a clinical peer reviewer will decide the second-level grievance.

4. The Health Plan will make its determination.

   a. Urgent Grievances

   If the second-level grievance relates to an urgent matter, the Health Plan will decide the second-level grievance and notify the member of the determination by phone within 24 hours of receipt of the second-level grievance request. Written notice will follow within 24 hours of the Health Plan's determination.

   b. Pre-Service Grievances

   If a second-level grievance relates to a pre-service matter, the Health Plan will decide the second-level grievance and notify the member of the determination in writing within 15 calendar days of receipt of the second-level grievance request.

   c. Post-Service Grievances

   If a second-level grievance relates to a post-service matter, the Health Plan will decide the second-level grievance and notify the member of the determination in writing within 30 calendar days of receipt of the second-level grievance request.

   d. Intangible Level 2 Grievances

   Intangible grievances include the following categories:

   - *Clinical Quality of Care*. A clinical quality concern is one that may adversely affect the health and/or well being of the member. Examples of this may include perceptions of inadequate or inappropriate treatment or failure to diagnose accurately.
   - *Access to Care.* Inability to obtain a timely appointment or an after hours appointment availability.
   - *Interpersonal Issues*. Interpersonal issues with a provider or his/her office staff or other complaints against the corporation.

   All intangibles must be resolved and the member notified within 45 calendar days after receipt of all information. The Health Plan will handle urgent clinical situations expeditiously. The Health Plan will notify the member of the results of the expedited review within 72 hours after receipt of all information.

5. Upon making its determination, the Health Plan will send a notice of determination of the second-level grievance that will include:
   - The name and title of the reviewer,
   - Detailed reasons for the determination, and, if the grievance involves a clinical matter,
   - The clinical rationale for the determination.

6. If a member remains dissatisfied with a first-level and/or second-level grievance determinations, or if he/she is dissatisfied at any other time, the member may:
   - Contact the New York State Department of Health, Corning Tower, Empire State Plaza, Albany, New York 12237, 1 (800) 206-8125,

     and/or
   - Contact the New York State Department of Insurance, Consumer Services Bureau, One Commerce Plaza, Albany, New York 12257, 1 (800) 342-3736.

4.14 Forms

The following form is reproduced on the next page:

- Specialist Referral Fax Form

Excellus BlueCross BlueShield, Rochester Region/Managed Care Provider Services

Specialist Referral Fax Form

Fax Completed Form to: (585) 238-3659

From: _____ Telephone Number: _____

Note: Referrals are automatically backdated 7 business days. If additional consideration is needed, please call Provider Services at (585) 454-4951 or (800) 462--0116.

1. Member ID _____ Patient's Name:_____
Date of Birth __/____/____ Referring Physician: _____
Referral Specialist: _____Time Period: 1 yr __ No end date _____
Diagnosis: _____Number of Visits: ____ Unlimited ___
Does referral meet benefit & protocol guidelines? ____Yes _____No
Plans Response:

---

2. MemberID _____ Patient's Name:_____
Date of Birth __/___/____ Referring Physician: _____
Referral Specialist: _____Time Period: 1 yr __ No end date _____
Diagnosis: _____Number of Visits: ____ Unlimited ___
Does referral meet benefit & protocol guidelines? ____Yes _____No
Plans Response:

---

3. MemberID _____ Patient's Name:_____
Date of Birth ___/____/____ Referring Physician: _____
Referral Specialist: _____Time Period: 1 yr __ No end date _____
Diagnosis: _____Number of Visits: ____ Unlimited ___
Does referral meet benefit & protocol guidelines? ____Yes _____No
Plans Response:
