meritus | Appeals Policy

Department: Compliance	**Title of Policy: Pre and Post Service Appeals**
Policy Number: C205	**Reference(s): NCQA UM 8 and RR 2 Element B**
Attachments: **Attachment A-** **Attachment B-**	**Approved by: Tina Lee** **Approval Date: 3/30/15**
Effective Date: 1/1/14	**Approved by: Sue Duncan** **Approval Date: 4/6/15**
Revision Date: 5/19/14, 3/17/15, 3/30/15	
Pages: 12	

I. PURPOSE

The purpose of this Policy (the "Policy") is to ensure that Meritus provides for thorough, appropriate, and timely resolution of pre and post service Appeals.

II. POLICY STATEMENT

It is the policy of Meritus to comply with all laws and regulations related to processing Appeals and to ensure that Appeals are processed in a timely, fair, and thorough manner, using an established and impartial process. Meritus ensures that members receive all of the services to which they are entitled and which are medically necessary.

III. DELEGATION OF RESPONSIBILITIES

The Director of Compliance will ensure that Appeals regarding Denied Claims are resolved in accordance with this policy and Arizona law. The Director of Clinical Integration will oversee the Appeals regarding a Denied Service are resolved in accordance with this policy and Arizona law.

IV. DEFINITIONS

UM 8A

RR2 Element B

A. Denied Claim: occurs when a person has already received care, a claim has been submitted for payment, and Meritus refuses to pay or any or a portion of the claim.

B. Denied Service: occurs when a person has requested a service or a referral to a specialist and Meritus refuses to pre-authorize the service. As a result, the desired service has not been rendered. A Denied Service may be eligible for an expedited appeal if the Member's treating physician submits a written certification indicating the

standard appeals process is “likely to cause significant negative change in the member’s medical condition.”

C. Member: a person who is covered under a health care plan provided by Meritus, or that person's treating provider, parent, legal guardian, surrogate who is authorized to make health care decisions for that person by a power of attorney, a court order or the provisions of section ARS 36-3231, or agent who is an adult and who has the authority to make health care treatment decisions for that person pursuant to a health care power of attorney.

V. REQUIREMENTS

A. Members are notified in writing of the appeal process, their appeal rights, included external appeal rights, and timeframes for submitting appeals. Meritus provides such notification in a culturally and linguistically appropriate manner. Language services are available to the member throughout the appeals process.

B. Appeals may be received in writing, by sending documentation to Meritus, Attn: Appeals Department, 2005 W 14th Street #113, Tempe, AZ 85281. Appeals may be sent electronically to appeals@meritusaz.com. Appeals may be filed verbally by calling 602-957-2113 and requesting to speak to an Appeals Coordinator. Appeals may be faxed to 855-568-2800.

UM 8B Factor 2

C. Members shall receive notification of the outcome of their administrative and quality of care appeals within thirty (30) days of the appeal being received. Urgent appeals will be responded to on a timely basis so that the member is able to receive services when deemed necessary, as defined by Meritus’ Chief Medical Officer, but in no case more than thirty (30) days.

RR 2 Element B.4

VI. PROCEDURES

Either the member or their treating provider can file an appeal on behalf of the member.

A. <u>Decisions a member can appeal</u>

1. Meritus does not approve a service that the member or their treating provider has requested.
2. Meritus does not pay for a service that the member has already received.
3. Meritus does not authorize a service or pay for a claim because Meritus says that it is not “medically necessary.”
4. Meritus does not authorize a service or pay for a claim because Meritus says that it is not covered under the member’s insurance policy, and the member believes it is covered.
5. Meritus does not notify the member, within 10 business days of receiving the request, whether or not Meritus will authorize a requested service.
6. Meritus does not authorize a referral to a specialist.

B. Decisions a member cannot appeal

1. The member disagree with Meritus' decision as to the amount of "usual and customary charges."
2. The member disagree with how Meritus is coordinating benefits when the member has health insurance with more than one insurer.
3. The member disagrees with how Meritus has applied the claims or services to the plan deductible.
4. The member disagrees with the amount of coinsurance or copayments that they paid.
5. The member disagrees with our decision to issue or not issue a policy to them.
6. The member is dissatisfied with any rate increases they may receive under their insurance policy.
7. The member believes Meritus has violated any other part of the Arizona Insurance Code.

C. Types of Appeals

Meritus makes the decisions at Level 1 and Level 2. An outside reviewer, who is completely independent from Meritus, makes Level 3 decisions.

Expedited Appeals (for urgently needed services not yet received)	**Standard Appeals** (for non-urgent services or denied claims)
Level 1- Expedited Medical Review	**Level 1**- Informal Reconsideration
Level 2- Expedited Appeal	**Level 2**- Formal Appeal
Level 3- Expedited External Independent Medical Review	**Level 3**- External Independent Medical Review

D. Expedited Appeal Process for Urgently Needed Services Not Yet Provided

1. Level 1: Expedited Medical Review

a. A member may obtain Expedited Medical Review of a denied request for a service that has not already been provided if:
   i. The member have coverage with Meritus,
   ii. Meritus denied a member's request for a covered service, and
   iii. The member's treating provider certifies in writing and provides supporting documentation that the time required to process the request through the Informal Reconsideration and Formal Appeal process (about 60 days) is likely to cause a significant negative change in the member's medical condition. The treating provider must send the certification and documentation to Meritus.

UM 8A Factors 9, 11, 14

RR 2B Factor 4

b. Meritus offers members expedited appeals for any urgent care request. Members are notified of their right to an expedited review at the time of the initial denial notification.

c. Meritus accepts Meritus' member appeals telephonically, electronically, and in writing. Members are informed in denial letters that expedited appeals are to be faxed directly to Meritus. Meritus staff are scheduled so that staff are always able to receive and make determinations about expedited appeals within 24 hours.

d. An expedited review begins when a member, the member's representative or a practitioner acting on behalf of the member requests an expedited appeal from Meritus.

e. Expedited appeal decisions are made, and members and practitioners notified within 24 hours of the request by telephone. This notification is followed by written notification within three calendar days.

f. Expedited review of appeals are granted to all requests concerning admissions, continued stay or other health care services for a member who has received emergency services but has not been discharged from a facility.

g. Practitioners may appeal on a member's behalf. If a practitioner is acting as a member's representative by filing an appeal, only the practitioner will be notified by Meritus of the decision, as it is presumed the practitioner is in contact with the member and will provide notification to them, since they are acting as patient representative.

h. Expedited appeals follow the same careful and thorough review and decision making as regular appeals, with a 24 hour time frame for rendering and communicating an appeal decision.

i. Meritus has 1 business day after the receipt of the information from the treating provider to decide whether the decision should be changed and authorize the requested service. Within that same business day, Meritus must call and tell the member and the treating provider, and mail the member the decision in writing. The written decision must explain the reasons for Meritus' decision and tell the member the documents on which the decision was based.

j. If Meritus denies the request: The member may immediately appeal to Level 2.

k. If Meritus grants the request: Meritus will authorize the service and the appeal is over.

l. If Meritus refers the case to Level 3: Meritus may decide to skip Level 1 and Level 2 and send the case straight to an independent reviewer at Level 3.

2. Level 2: Expedited Appeal

If Meritus denies a member's request at Level 1, the member must request an Expedited Appeal. After the member receives Meritus' level 1 denial, the treating

provider must immediately send Meritus a written request to tell us the member is appealing to Level 2. The treating provider should also send any more information not previously sent to show why the member needs the requested service. Meritus has 3 business days after receipt of the request to make a decision. If the request is denied, the member may immediately appeal to Level 3. Meritus may also choose to skip the Level 2 review and send the case straight to Level 3.

3. Level 3: Expedited External, Independent Review

The member may appeal to Level 3 only after they have appealed through Levels 1 and 2. The member has only 5 business days after receipt of Meritus' Level 2 decision to send a written request for Expedited External Independent Review. The member is not responsible to pay the costs of the external review.

4. There are two types of Level 3 Independent Review appeals, depending on the issues of the case:

4.1 Medical Necessity- cases where Meritus decided not to authorize a service because the requested services were deemed not medically necessary. For medical necessity cases, the independent reviewer is a provider retained by an outside independent review organization ("IRO"), that is procured by the Arizona Insurance Department, and not connected with Meritus. The IRO provider must be a provider who typically manages the condition under review.

a. Within 1 business day of receiving the request, Meritus must:

i. Mail a written acknowledgement of the request to the Director of Insurance, the member, and the treating provider.

ii. Send the Director of Insurance: the request for review; the member's policy, evidence of coverage or similar document; all medical records and supporting documentation used to render Meritus' decision; a summary of the applicable issues including a statement of the decision; the criteria used and clinical reasons for the decision; and the relevant portions of the utilization review guidelines. Meritus must also include the name and credentials of the health care provider who reviewed and upheld the denial at the earlier appeal levels.

b. Within 2 business days of receiving our information, the Insurance Director must send all the submitted information to an external independent reviewer organization (the "IRO").

c. Within 72 hours of receiving the information the IRO must make a decision and send the decision to the Insurance Director.

d. Within 1 business day of receiving the IRO's decision, the Insurance Director must mail a notice of the decision to Meritus, the member, and the treating provider.

e. The decision (medical necessity): If the IRO decides that Meritus should provide the service, Meritus must authorize the service. If the IRO agrees with the decision to deny the service, the appeal is over. The member's only further option is to pursue the claim in Superior Court.

4.2. Contract Coverage- cases where Meritus denied coverage because it is believed the requested service is not covered under the member's insurance policy. For these cases, the Arizona Insurance Department is the independent reviewer.

a. Within 1 business day of receiving the request, Meritus must:

i. Mail a written acknowledgement of the request to the Insurance Director, the member, and the treating provider.

ii. Send the Director of Insurance: the request for review, the member's policy, evidence of coverage or similar document, all medical records and supporting documentation used to render the decision, a summary of the applicable issues including a statement of the decision, the criteria used and any clinical reasons for the decision and the relevant portions of the utilization review guidelines.

b. Within 2 business days of receiving this information, the Insurance Director must determine if the service or claim is covered, issue a decision, and send a notice to Meritus, the member, and the treating provider.

c. Referral to the IRO for contract coverage cases: The Insurance Director is sometimes unable to determine issues of coverage. If this occurs, the Insurance Director will forward the case to an IRO. The IRO will have 5 business days to make a decision and send it to the Insurance Director. The Insurance Director will have 1 business day after receiving the IRO's decision to send the decision to Meritus, the member, and the treating provider.

d. The decision (contract coverage): If the member disagrees with Insurance Director's final decision on a contract coverage issue, they may request a hearing with the Office of Administrative Hearings ("OAH"). If Meritus disagrees with the Director's final decision, Meritus may also request a hearing before OAH. A hearing must be requested within 30 days of receiving the Director's decision. OAH must promptly schedule and complete a hearing for appeals from expedited Level 3 decisions.

E. Standard Appeal Process for Non-Urgent Services and Denied Claims

1. Level 1: Informal Reconsideration

a. A member may obtain an Informal Reconsideration of a denied request for a service or claim if:

i. The member has coverage with Meritus;
ii. Meritus denied a request for a covered service or claim;
iii. The member does not qualify for an expedited appeal;

iv. The member or treating provider asks for Informal Reconsideration within 2 years of the date Meritus first denies the requested service or claim by calling, writing, or faxing the request to Meritus.

b. A member may not obtain Information Reconsideration of a denied request for the payment of a covered service. Instead, the member may start the review process by seeking a Formal Appeal.

c. Meritus has 5 business days after the receipt of the request for Informal Reconsideration to send the member and the treating provider a notice that Meritus has received the request.

d. Meritus has 30 days after the receipt date of the request to decide whether or not to change the decision and authorize the requested service or pay the claim. Within that same 30 days, Meritus must send the member and treating provider the written decision. The written decision must explain the reasons for the decision and inform what documents on which the decision was based. The initial denial is not considered when an appeal is filed.

UM 8A Factors 1-6

RR 2B Factor 4

e. Members may submit written comments, documents, records and any other information relevant to the appeal. This information will be considered by the organization during the appeal process. Members are notified of this right in their original denial letter.

f. The person appointed to review the appeal will never be the same person who made the original denial decision, or a subordinate of the person who made the original denial decision. A physician or clinical peer will review all appeals.

g. Appeals that involve clinical issues, such as determining if a treatment, drug or item is experimental, investigational, or not medically necessary or appropriate will always be reviewed by a health care practitioner with appropriate training and experience in the field of medicine involved in the case.

h. If Meritus denies the request, the member has 60 days to appeal to Level 2.

i. Meritus may decide to skip Level 1 and Level 2 and send the case straight to an independent reviewer at Level 3.

2. Level 2: Formal Appeal

a. The member may request Formal Appeal if: (1) Meritus denies the request at Level 1, or (2) the member has an unpaid claim and Meritus did not provide a Level 1 review. After the member receives Meritus' Level 1 denial, the member or the treating provider must send Meritus a written request within 60 days to tell Meritus that the case is being appealed to Level 2. If Meritus did not provide a Level 1 review of the denied claim, the member has 2 years from the first denial notice to request Formal Appeal. To help

Meritus make a decision on the appeal, the member or the provider should also send any more information not previously sent to show why Meritus should authorize the requested service or pay the claim.

b. Meritus has 5 business days after receipt of the request for Formal Appeal to send the member and the treating provider a notice that Meritus received the request.

c. For a denied service that has not yet been received, Meritus has 30 days after the receipt date to decide whether to change the decision and authorize the requested service. For denied claims, Meritus has 60 days to decide whether to change the decision and pay the claim. Meritus will send the member and the treating provider the decision in writing. The written decision must explain the reasons for the decision and tell the documents on which the decision was based.

d. If Meritus denies the request, the member has 4 months to appeal to Level 3. Meritus may decide to skip Level 2 and send the case straight to an independent reviewer at Level 3.

3. Level 3: External, Independent Review

a. The member may appeal to Level 3 only after they have appealed through Levels 1 and 2. The member has 4 months after receipt of Meritus' Level 2 decision to send a written request for Expedited External Independent Review. The member is not responsible to pay the costs of the external review.

UM 8B Factor 2

b. Meritus notifies members at least annually of the availability of external appeals and the right to independent review. Notification is provided in the member welcome packet, on the Meritus webpage and in an annual mailing to all members.

4. There are two types of Level 3 Independent Review appeals, depending on the issues of the case:

4.1 Medical Necessity- cases where Meritus decided not to authorize a service because it was determined the requested services are not medically necessary. For medical necessity cases, the independent reviewer is a provider retained by an outside independent review organization ("IRO"), that is procured by the Arizona Insurance Department, and not connected with Meritus. The IRO provider must be a provider who typically manages the condition under review.

a. Within 5 business days of receiving the request, Meritus must:

i. Mail a written acknowledgement of the request to the Director of Insurance, the member, and the treating provider.

ii. Send the Director of Insurance: the request for review, the member's policy, evidence of coverage or similar document; all medical records and supporting

documentation used to render the decision; a summary of the applicable issues including a statement of the decision; the criteria used and clinical reasons for the decision; and the relevant portions of the utilization review guidelines. Meritus must also include the name and credentials of the health care provider who reviewed and upheld the denial at the earlier appeal levels.

b. Within 5 days of receiving the information, the Insurance Director must send all the submitted information to an external independent review organization (the "IRO").

c. Within 21 days of receiving the information the IRO must make a decision and send the decision to the Insurance Director.

d. Within 5 business days of receiving the IRO's decision, the Insurance Director must mail a notice of the decision to Meritus, the member, and the treating provider.

e. The decision (medical necessity): If the IRO decides that Meritus should provide the service or pay the claim, Meritus must authorize the service or pay the claim. If the IRO agrees with the decision to deny the service or payment, the appeal is over. The only further option is to pursue the claim in Superior Court.

4.2 Contract Coverage- cases where Meritus has denied coverage because it is believed the requested service is not covered under the member's insurance policy. For contract coverage cases, the Arizona Insurance Department is the independent reviewer.

a. Within 5 business days of receiving the request, Meritus must:

i. Mail a written acknowledgement of the request to the Insurance Director, the member, and the treating provider.

ii. Send the Director of Insurance: the request for review; the member's policy, evidence of coverage or similar document; all medical records and supporting documentation used to render the decision; a summary of the applicable issues including a statement of the decision; the criteria used and any clinical reasons for the decision; and the relevant portions of the utilization review guidelines.

b. Within 15 business days of receiving this information, the Insurance Director must determine if the service or claim is covered, issue a decision, and send a notice to Meritus, the member, and the treating provider. If the Director decides that Meritus should provide the service or pay the claim, Meritus must do so.

c. Referral to the IRO for contract coverage cases: The Insurance Director is sometimes unable to determine issues of coverage. If this occurs, the Insurance Director will forward the case to an IRO. The IRO will have 21 days to make a decision and send it to the Insurance Director. The Insurance Director will have 5

business days after receiving the IRO's decision to send the decision to Meritus, the member, and the treating provider.

d. The decision (contract coverage): If the member disagrees with the Insurance Director's final decision on a coverage issue, they may request a hearing with the Office of Administrative Hearings ("OAH"). If Meritus disagrees with the Director's determination of coverage issues, Meritus may also request a hearing at OAH. Hearings must be requested within 30 days of receiving the coverage issue determination. OAH has rules that govern the conduct of their hearing proceedings.

F. Obtaining Medical Records

Arizona law (A.R.S. §12-2293) permits the member to ask for a copy of their medical records. The request must be in writing and must specify who the member wants to receive the records. The health care provider who has the records will provide the member or the person they specified with a copy of the records.

1. Designated Decision-Maker: If the member has a designated health care decision-maker, that person must send a written request for access to or copies of the medical records. The medical records must be provided to the member's health care decision-maker or a person designated in writing by the health care decision-maker unless the member limits access to their medical records only to themselves or their health care decision-maker.

2. Confidentiality: Medical records disclosed under A.R.S. §12-2293 remain confidential. If the member participates in the appeal process, the relevant portions of the medical records may be disclosed only to people authorized to participate in the review process for the medical condition under review. These people may not disclose the member's medical information to any other people.

G. Documentation for an Appeal

1. If the member decides to file an appeal, they must give Meritus any material justification or documentation for the appeal at the time the appeal is filed. If the member gathers new information during the course of the appeal, the member should give it to Meritus as soon as they get it. The member must also give Meritus the address and phone number where they can be contacted. If the appeal is already at Level 3, the member should also send the information to the Department of Insurance.

2. Written documentation of Appeal review and decisions include the following:
a. The specific reasons for the appeal decision, in easy to understand language
A reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based.

b. Notification that the member can obtain a copy free of charge, upon request, of the actual benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based.

c. Notification that the member can obtain, upon request and at no additional charge, reasonable access to and copies of all documents relevant to the appeal including any new or additional evidence.

d. The notice includes a statement of which individuals participated in the appeal review, including the title of each reviewer for benefit appeals and the title, qualifications and specialty of each reviewer for medical necessity reviews. The specific names of reviewers may or may not be on notifications to members, but will be provided if a member requests them.

e. A description of the next level of appeal, either within the organization or to an external organization, as applicable, along with any relevant written procedures.

f. If Meritus completely overturns the denial, the appeal notice will state the decision and the date

H. <u>Specific Notification in Final Denial Letters</u>

UM 8A Factor 10
UM 8B Factor 1
RR 2B Factor 3

1. Final denial letters state what appeal rights are available and provide members with clear directions on how to use the external appeal process. The letter includes the following two information elements:

a. Under some circumstances, appeals may be eligible for external review.

b. Information on how the member can seek further information about these rights.

I. <u>Cultural Sensitivity</u>

RR 2B Factor 5

1. Meritus accepts appeal requests and responds in the member's primary language.

2. Meritus utilizes an interpreter service to translate the member's written or verbal request into English.

3. The interpreter service translates the Meritus appeal resolution notice in the same language as what the appeal was submitted in.

4. Both denial letters and the appeal resolution notice includes a statement in Spanish (the main language other than English in AZ) informing members how to contact Meritus to obtain this information in their language.

J. <u>Claims Disputes Not Requiring an IER Option</u>

1. Independent External Reviews are only offered to Providers in instances where Meritus has denied a claim. If Meritus pays any portion of a Claim, such as a Short Pay dispute, the Provider is not eligible for an Independent External Review.

VII. REVISION HISTORY

Review Date	Reviewed by:	Reason for Change:
5/19/14	Alison Johnson	Complete Rewrite
3/17/15	Crystal Cabrera	Complete Rewrite
3/30/15	Tina Lee	Rewrote Definition section and changed to a Compliance policy