



# *Compliance And Appeals*

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## I. UTILIZATION REVIEW COMPLIANCE POLICY

If through the review of claims, pre-certification/concurrent review data, or medical records BCBSKS identifies a possible pattern of irregularities, the case will be reviewed by the BCBSKS medical director. A pattern of irregularities includes, but is not limited to, inconsistencies between pre-certification data and documentation in the medical record or failure to implement the treatment plan.

After review by and at his discretions, the medical director may request a chart audit. If this occurs, the institutional relations consultants will notify the provider.

- **AUDIT PROCESS**

The provider will submit complete medical records on cases identified by BCBSKS.

BCBSKS will compare the written documentation to the information furnished during the pre-certification process and will review the medical necessity of the services, implementation of the treatment plan, and any other issues relevant to the case.

- **AUDIT RESULTS**

Upon completion of the audit, a meeting with the provider will be held to discuss audit results. Prior to the meeting, the provider will receive written documentation from BCBSKS identifying specific issues.

BCBSKS staff attending this meeting will be the institutional provider consultant and medical review staff could also be included.

- **CORRECTIVE PLAN OF ACTION**

Within 30 days of the audit results meeting, the provider will submit to BCBSKS a corrective plan of action relating to any problems identified. The plan must be approved by BCBSKS. The provider then has three months to correct the problems.

- **REAUDIT**

Three months after approving the corrective plan of action, BCBSKS will conduct a reaudit. The purpose of this reaudit is to insure that the plan has been implemented and the issues resolved. This audit will be of cases occurring since the plan of action was accepted.

If issues remain, the provider will be required to submit the medical record for pre-certification/concurrent review as indicated below.

- **RECORD SUBMISSION FOR PRE-CERTIFICATION/CONCURRENT REVIEW**

During the initial audit process, if the severity of the issues warrant, BCBSKS may immediately require that the provider submit medical records for pre-certification or concurrent review. This may also occur to providers when issues remain unresolved during the reaudit.

After six months, if issues have resolved, telephonic or online pre-certification or concurrent review will again be accepted. The medical record would, however, be required to be submitted with the claim for prepayment review.

This process will continue for an additional six months as long as there is 100% correlation between telephonic or online information and the medical record. If inconsistencies are again identified, remedies as prescribed by policies, procedures, and contracting provider agreement will be considered. Provider agreements may be cancelled for noncompliance and cause.

Cases that were not pre-certified or were reviewed on a retrospective basis must have a medical necessity denial rate of 10% or less.

## **II. APPEALS**

### **RIGHT OF APPEAL**

The Contracting Provider shall have the right to appeal a claim that has been denied based on lack of medical necessity, a service being experimental/investigational or a MS-DRG assignment.

During any level of the contracting provider's appeal, only documents contained in the provider or physician medical records for the inpatient stay or outpatient encounter in question will be considered. All record information must be provided at the initial appeal.

Any health care practitioner's (including physician's) patient case recollection, case summary, case study or case analysis of any kind, not part of the initial medical record, will not be considered during the appeals process.

Contracting providers shall not bill BCBSKS members for medically unnecessary services unless the members have been notified in advance that specific services, which they are going to receive, will be their responsibility.

## **PROVIDER APPEALS FOR EXPERIMENTAL/INVESTIGATIONAL OR NOT MEDICALLY NECESSARY SERVICES**

### **Claim Denial When Notice of Personal Financial Obligation Is Not Given**

The guidelines in this section apply when claims have been denied not medically necessary or if the service is experimental/investigational and a [Notice of Personal Financial Obligation \(NOPFO\)](#) has been signed by the patient. When this occurs, the contracting provider may not bill the member for the denied charges.

Before entering into the appeals process, the contracting provider may verify the original payment determination through established inquiry procedures. The inquiry to verify the original payment determination should be made within 180 days of the date of the remittance advice.

In cases where claims are adjusted, the remittance advice will serve as the written response.

**Initial Appeal:** Written notification of disagreement with a medical necessity determination shall be provided to BCBSKS within 180 days of the date of the remittance advice. This notice shall be considered an Initial Appeal and should be forwarded with all pertinent information to BCBSKS Customer Service Center. Information submitted with the request for Initial Appeal will be referred to the appropriate consultant and a determination will be provided. This decision will be binding unless the provider appeals the decision within 60 days of notification.

**Final Appeal:** A Final Appeal may be initiated by forwarding a written request to the BCBSKS customer service center, with a letter addressed to the Chief Medical Officer. The Final Appeal determination shall be made by the Chief Medical Officer. The contracting provider contractually agrees to abide by the final determination in the appeals process.

All appeal decisions made by BCBSKS must be conveyed within 60 days of receipt of the provider's request. Any appeals decision not provided within the aforementioned time frames shall be considered as decisions made in favor of the provider, and claim payments will be adjusted accordingly. Cases may only be appealed once at each level. The contracting provider agrees to accept the determination made at each level or to appeal the claim at the next step of the appeals process. If throughout the appeals process the decision on the claim changes in the provider's favor, an additional payment will be made. A refund will be requested if the decision reverses a previous determination (either partially or totally).

The result of the appeals process shall be binding on the provider and BCBSKS, subject only to the provision for binding arbitration.

**POST-PAYMENT AUDIT APPEALS**

BCBSKS conducts periodic post-payment audits of patient records to substantiate the medical necessity of services billed on the provider claim. BCBSKS provides education through policy memos, medical policy, newsletters, workshops, direct correspondence, and onsite visits. In audits where audit findings conclude that education did not occur, BCBSKS will then provide education. If education does not resolve subsequent medical necessity findings, BCBSKS will seek refunds for those paid claims. If claims include billing for services not documented, then BCBSKS will request refunds and may refer the case for further investigation.

Post pay refund requests based on medical necessity must have an appeal filed in writing within 30 days of the refund request. The provider must include all relevant documentation with the appeal. BCBSKS' determination will be made within 30 days of receipt of the appeal.

A provider may request a second and final appeal in writing within 30 days of notification of the appeal determination. The second and final appeal determination will be made by the BCBSKS Chief Medical Officer within 30 days. When findings reveal issues, which are presently specified in the BCBSKS policies, billing guidelines or newsletters relating to content of service, multiple surgery guidelines, and other billing and/or reimbursement guidelines, the terms of this appeal are not available.

**MEMBER APPEALS**

Claims Denial After Notice of Personal Financial Obligation is Given

In situations where services are denied as non-covered and where the member is determined to be financially responsible for the claim and acknowledges responsibility, which includes an approximate amount of the charge, the member shall have appeal rights, which are governed by Plan documents applicable to the member. In such circumstances, the contracting provider may appeal as the member authorized representative if the member so requests in writing, and must follow the guidelines governed by Employee Retirement Income Security Act of 1974 (ERISA) and/or the benefit plan documents applicable to the member.

**PRECERTIFICATION AND CONCURRENT REVIEW APPEAL**

BCBSKS follows URAC guidelines for precertification and concurrent review appeals. These appeal options are only available prior to claim submission and are subject to time frames as established by BCBSKS, Department of Labor and URAC. All precertification and concurrent

review appeals will be reviewed concomitantly. Based on the type of admission, an expedited or standard appeal may be requested by the provider.

**Expedited Appeal** – This appeal process is used for urgent care precertification and concurrent review requests. It should be requested within one business day of the verbal denial. Documentation for review must be faxed and should include all or part of the medical record and/or a written statement from the provider. BCBSKS has 72 hours to respond to this appeal. If the denial is reversed, the concurrent review process will continue.

**Standard Appeal** – This appeal process is available for non-urgent care and must be requested within 180 calendar days of the date of the denial notification or denial letter and before the claim is submitted. Requests beyond 180 calendar days of initial notification or after the claim has been submitted have no further appeal rights under this provision.

Documentation must be provided at the time of the appeal and should include all or part of the medical record and/or a written statement from the provider. BCBSKS has up to 30 days to provide a written response to this appeal.

### **MS-DRG ASSIGNMENT**

The contracting provider may appeal the MS-DRG assignment on any inpatient stay.

**Initial Appeal** - Written notification of this appeal shall be provided to BCBSKS within 45 days of the initial payment on the appealed claim. This notification as well as any additional information, which the contracting provider may provide, will be reviewed by the BCBSKS Reimbursement Staff Review Committee, who will provide a decision regarding MS-DRG assignment and notify the contracting provider of that decision within 30 days of receipt of the request.

**Final Appeal** - The contracting provider shall have the right to appeal the decision of the Reimbursement Staff Review Committee to the Vice President of Provider Relations and Medical Affairs. The Vice President of Provider Relations and Medical Affairs shall deliver a decision on the matter considering information provided by the Reimbursement Staff Review Committee and the contracting provider. This decision shall be final. The request for reconsideration from the contracting provider must be submitted within 30 days notice of the Reimbursement Staff Review Committee decision.

Appeals to the Vice President of Provider Relations and Medical Affairs must have a decision within 30 days of the provider's request. Any appeals decision not provided within the aforementioned time frames shall be considered as decisions made in favor of the provider. All monies previously withheld related to these cases shall be reinstated.

### III. NOTICE OF PERSONAL FINANCIAL OBLIGATION

Providers will not bill members for services which have been determined medically unnecessary or experimental/investigational unless the member has been given written notification in advance that **specify** medically unnecessary or experimental/investigational services will be the member's responsibility. This notification is referred to as the [Notice of Personal Financial Obligation](#). Generic or all-encompassing notifications without advanced written authorization by Blue Cross and Blue Shield shall not be deemed to meet the specific notification requirements mentioned above. In instances where medical necessity is questionable, the provider may contact Blue Cross and Blue Shield for a predetermination of coverage at 1-800-782-4437. If services are for mental health, contact New Directions at 1-800-952-5906. This guideline applies to inpatient, outpatient and partial-day services.

All claims for services that are medically unnecessary or experimental/investigational and for which the member has been given a Notice of Personal Financial Obligation shall be submitted on a paper UB-04/837I claim form with the Notice of Personal Financial Obligation form attached. Charges shall be billed as non-covered.

Note: If the member does not want the claim to be filed, obtain this instruction in writing from the member and keep it on file with the Notice of Personal Financial Obligation.

Blue Cross and Blue Shield staff developed a Notice of Personal Financial Obligation that can be used by providers to meet this requirement. Providers are not obligated to use this exact form; however, if developing their own, it must be specific and we suggest that it be sent to the provider consultant for review prior to its use. The use of non-specific or incomplete forms places the provider at financial risk.

## **IV. MEDICAL NECESSITY DEFINITION**

Medically necessary means a service required to diagnose or to treat an illness or injury. To be medically necessary, the service must:

1. Be performed or prescribed by a doctor,
2. Be consistent with the diagnosis and treatment of the condition.
3. Be in accordance with standards of good medical practice.
4. Not be for the convenience of the patient or the doctor, and
5. Is provided in the most appropriate setting.

## **V. EXPERIMENTAL/INVESTIGATIONAL DEFINITION**

Experimental or Investigational refers to the status of a drug, device, medical treatment or procedure:

- If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished and the drug or device is not research-urgent (see the Glossary section for definition) as defined by the BCBSKS member contract; or
- If credible evidence (see the Glossary section for definition) show that the drug, device, medical treatment or procedure is the subject of ongoing phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis and the trials are not research-urgent as defined by the BCBSKS member contract; or
- If credible evidence shows that the consensus among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis and the trials are not research-urgent as defined by the BCBSKS member contract; or
- If there is no credible evidence available that would support the use of the drug, device, medical treatment or procedure compared to the standard means of treatment or diagnosis.