

# Appeals

---

This section contains information about provider appeals and member appeals, but does not include hospital appeals information.

## Hospital Appeals

Hospital appeals follow the process outlined in the hospital's current agreement with Regence BlueCross BlueShield of Oregon. Contact your provider services representative to obtain a copy of your hospital agreement, if necessary.

## Provider Billing Dispute and Medical Necessity/Investigational Procedure Determination Appeal Process

### Introduction

#### A. Applicability

The Regence Provider Billing Dispute and Medical Necessity/Investigational Procedure Determination Appeal Process (Adverse Determination Appeal Process) will apply when the Provider is at financial risk for the cost of the claim. The member appeal process will apply when the Member is or may be at financial risk for the cost of the claim. For purposes of Billing Disputes only, the definition of Provider shall include providers who contract with Regence as participating providers and non-contracted providers.

### Internal Review Process

#### A. Time Period for Submission of an Adverse Determination Appeal by Provider

An Adverse Determination Appeal must be submitted in writing within the following timeframes:

1. For Oregon, Idaho or Utah Providers, within 18 months after payment of the claim or notice that the claim was denied.
2. For Washington Providers, 24 months after payment of the claim or notice that the claim was denied or 30 months for claims subject to coordination of benefits.

Failure to request review within the stated time period (absent a finding which, in our sole discretion, sets forth acceptable extenuating circumstances) will preclude the right to appeal and may jeopardize the right to contest the decision in any forum.

## **B. Process for Submission of an Adverse Determination Appeal**

1. A provider may use the *Provider Billing Dispute and Medical Necessity or Investigational Denial Appeal* form, which can be found on our *Provider Web Site*: [www.or.regence.com/provider](http://www.or.regence.com/provider)
2. The *Provider Billing Dispute and Medical Necessity or Investigational Denial Appeal* form or a written description of the issue(s) on appeal must be submitted to Regence either by mail or facsimile at the addresses below:

### **By mail:**

Regence  
Attention: Provider Appeals  
P.O. Box 1239 MS E9A  
Portland, OR 97207

### **By facsimile:**

Provider Appeals  
1 (866) 273-1820

3. The following information must be submitted with the *Provider Adverse Determination Appeal* form or the written description of the issue(s) on appeal:
  - (a) A detailed description of the disputed issue(s);
  - (b) The basis for disagreement with the decision; and
  - (c) All evidence and documentation supporting your position.

## **C. Review Process**

1. The individual reviewing the issue(s) on appeal will meet the following criteria:
  - (a) Is not an individual who made or consulted in the initial determination,
  - (b) Is not a subordinate of an individual involved in the initial determination.
2. A written notification of the Internal Review determination will be sent to you upon completion.
3. If the initial determination is upheld, you have the option to seek External Review or one of the other dispute resolution processes set forth in the Provider Agreement. A description of the External Review option will be supplied, including the time limit for requesting External Review. The time limit for requesting External Review is ninety (90) days after the written Internal Review determination.

## **D. Additional Provisions for Billing Disputes Only**

Regence will communicate a decision on an Internal Review of a Billing Dispute within thirty (30) days of our receipt of all documentation reasonably needed to decide the Billing Dispute.

## **E. Additional Provisions for Medical Necessity/Investigational Procedure Adverse Determination Appeals Only**

### **1. Eligible Adverse Determination Appeals**

Adverse Determination Appeals from either pre-service or post-service determinations by us that certain services are not covered services because they are/were not Medically Necessary or are/were Investigational. However the following will not be considered to be eligible appeals:

- (a) Appeals made by non contracting providers
- (b) Appeals of post service claims where the member or provider sought a pre-service appeal of the same claim.
- (c) Appeal of a post service claim where the member has appealed the same claim.
- (d) For external review only; the member is covered under a Self-Insured Plan and the Plan sponsor has not agreed by contract to participate in our External Review program.
- (e) The member has filed suit under Section 502 of ERISA or other suit for denial of the health care services or supplies regarding an Adverse Determination.

### **2. Timeline**

A written internal review determination will be provided no later than sixty (60) days after receipt of the request for Internal Review of an Adverse Determination Appeal.

### **3. Qualified Reviewer**

For an Internal Review pertaining to a Medical Necessity Appeal or an Investigational Procedure Appeal, only a Provider in the same specialty, other than the Provider that made the initial Adverse Determination, may deny the appeal of the Provider who treated the condition. A nurse or other health care professional employed by Regence may review the Medical Necessity appeal or the Investigational Procedure Appeal and may grant but not deny it. If the nurse or other health care professional does not grant the appeal, then a Qualified Reviewer, designated by Regence, other than the one that made the initial Adverse Determination, shall review and decide the Medical Necessity Appeal or Investigational Procedure Appeal in accordance with our medical and reimbursement guidelines.

For purposes of this section, "same specialty" means a provider with similar credentials and licensure as those who typically treat the condition or health problem in question in the appeal or a provider who has experience and/or has training in the treatment of the same problems as those in question in the appeal, and experience and/or training in the treatment of similar complications of those problems.

## **Provider External Review Process**

If the initial determination is upheld through the Internal Review process, the option to seek External Review of the determination through an External Reviewer will be made available.

**A. Prerequisites for External Review:**

1. The Internal Review process must be exhausted before requesting an External Review of the determination unless both Regence and the provider agree to forego the Internal Review process and proceed directly to External Review or, in the case of a Medical Necessity Appeal or an Investigational Procedure Appeal, we cannot provide a Qualified Reviewer.
2. A provider who chooses External Review will submit a written notice to the External Reviewer within ninety (90) days from the date of the Internal Review Determination.

**B. External Review Provisions Applicable Only to Billing Disputes**

1. A Billing Dispute may be submitted to the External Reviewer when the amount in dispute exceeds \$500 unless the provider notifies the External Reviewer that he or she intends to submit additional Billing Disputes on the same or similar issues during the one-year period following the submission of the original Billing Dispute. The request for External Review is at the option of the provider, who may instead choose any other dispute resolution allowed by the Provider Agreement. If chosen, the External Review shall be binding.
2. The Billing Dispute Adverse Determination Appeal must be submitted to the External Reviewer in the following manner:

**By mail:**

MES Peer Review Services  
100 Morse St.  
Norwood, MA 02062

**By facsimile:**

1 (888) 868-2087

**By Internet:** A link to the External Reviewer Web site is available on our *Provider Web Site*.

3. For an External Review pertaining to a Billing Dispute, the provider shall pay to the External Reviewer a filing fee calculated as follows:
  - (a) If the amount in dispute is \$1,000 or less, the filing fee shall be equal to \$50; or,
  - (b) If the amount in dispute exceeds \$1,000, the filing fee shall be equal to \$50 plus five (5) percent of the amount by which the amount in dispute exceeds \$1,000, but in no event shall the fee be greater than fifty (50) percent of the cost of the review.
  - (c) Payment must be submitted along with the External Review request; provided, however, that the provider shall be entitled to a refund of such payment in the event that the provider prevails in the External Review process.
4. Upon notification to Regence that a timely Billing Dispute Appeal has been submitted for External Review and the filing fee has been received, we will provide to the External Reviewer the Appeal Record no later than thirty (30) days after requested by the External Reviewer.

5. In the event that the External Review decision requires payment by Regence, such payment will be made within fifteen (15) days after we receive notice of the determination.

### **C. Provisions Applicable Only to Medical Necessity/Investigational Procedure Determination**

1. For an External Review pertaining to a Medical Necessity Appeal or Investigational Procedure Appeal, the provider shall pay to the External Reviewer a filing fee of \$50 if the amount in dispute is \$1,000 or less, or \$250 if the amount in dispute exceeds \$1,000. Payment must be submitted along with the External Review request.
2. The request for External Review must be submitted in writing and include a description of the issue(s) on appeal to the External Reviewer by either mail or facsimile at the address below:

**By mail:**

MES Peer Review Services  
100 Morse St.  
Norwood, MA 02062

**By facsimile:**

1 (888) 868-2087

**By Internet:** A link to the external reviewer Web site is available on our *Provider Web Site*.

3. The request for External Review is at the option of the provider, who may instead choose any other dispute resolution process allowed by the Provider Agreement. If this option is chosen, the External Review shall be binding.

## **Audit Appeal Process**

The Audit Appeal Process is intended to give you an opportunity to request reconsideration of audit findings issued by Regence and to ensure we have reviewed all information relevant to the audit findings. Please note that contract terminations resulting from audit findings must follow the Provider Contract Termination Appeal Process.

### **1. Reconsideration Request**

Upon receipt of our audit findings, you have **forty-five (45) business days** to review and dispute these findings before the audit becomes final. In order to appeal the findings, you must submit a written request for a reconsideration of audit findings. You will be given the address for where to send your reconsideration request with your audit findings.

The request must be received by Regence within **forty-five (45) business days** of your receipt of the audit findings and must include, at a minimum, the following:

- A detailed statement of the issue(s) in dispute
- At the election of the provider, notification of a request for a meeting with the panel reviewing the issue(s) in dispute
- Any documents which the provider contends supports his/her position  
(Exception: Please note that all documentation required to justify your billing, including but not limited to chart notes, to be present in your files at the time of an audit. Additions to file documentation and/or the production of files that were not made available to us at the time of an audit will not be considered in connection with an appeal involving adverse audit findings. We will, however, consider your explanation as to why the documentation was not present at the time of the audit.)

If we do not receive such a reconsideration request within forty-five (45) business days of your receipt of the audit findings, the findings will be final.

The request for reconsideration will be reviewed by the manager of the department that sent you the audit findings, investigators within that department, and other Regence representatives, as determined by the manager of the department (hereinafter referred to as the "Panel"). At the discretion of the Panel, a Regence Medical Director may be consulted prior to the final decision.

A meeting, prior to the Panel's review of your request for reconsideration, can be arranged either at your office or a Regence office, as mutually convenient. You must request this meeting when submitting your request for reconsideration.

At the meeting, you may appear in person and may be accompanied by an attorney or other representative. You and your representative may make an oral statement to the Panel and respond to questions from the Panel. The purpose of this meeting is to give you an opportunity to present its position to the Panel in person.

If the Panel needs additional documentation to reach a decision, the additional documentation must be submitted within **twenty (20) calendar days** of the date of the written request for information, unless a written request for a reasonable extension of time is granted.

- If the requested documentation is received on time, it will be included in the request for reconsideration.
- If the documentation is not received on time, the request for reconsideration will continue and a decision will be made based on the information originally submitted.

You will be sent written notice of the decision within **forty-five (45) business days** following the meeting with the Panel or, if no such meeting was requested, within **forty-five (45) business days** of our receipt of the audit reconsideration request, not including the time waiting for additional information from you. During the period of time in which we are waiting for additional information, the appeal decision time frame is suspended until the information is received or the time to respond to the request has expired.

**The decision on an audit reconsideration request is deemed final forty-five (45) business days after your receipt of the Panel's decision, unless a timely written request for a Medical Director Review is received.**

## **2. Medical Director Review**

If you are not satisfied with the decision made following the reconsideration request to the Panel, you may request a Medical Director Review of the audit findings. The written request for a Medical Director Review and any supporting information must be received by Regence within **forty-five (45) business days** of your receipt of the Panel's decision. The address where to send your request will be included in our response to your request for reconsideration.

The Medical Director Review will be held no more than forty-five (45) business days following receipt of the request, not including the time in which the Company is waiting for additional information from you. The review will be conducted by a Medical Director who was not involved in an earlier review of the audit findings.

If the Medical Director needs additional documentation to reach a decision, the additional documentation must be submitted within **twenty (20) calendar days** of the date of the written request for information, unless a written request for a reasonable extension of time is granted.

- If the requested documentation is received on time, it will be included in the Medical Director Review.
- If the documentation is not received on time, the Medical Director Review will continue and a decision will be made based on the information originally submitted.

During the period of time in which the Company is waiting for additional information, the forty-five (45) business day clock to complete the Medical Director Review is suspended until the information is received or the time to respond to the request has expired.

You will be sent written notice of the decision within **forty-five (45) business days** following the Medical Director Review.

**The Medical Director Review is the final step in the Audit Appeal Process. Once a decision has been made by the Medical Director, the Audit Appeal Process has been completed and the decision shall be deemed final. If you are not satisfied with the Company's decision after completing the Audit Appeal Process and want to continue to dispute the issue(s), you must initiate the appropriate process(es) as outlined in your provider contract.**

# Provider Contract Termination Appeals

A contracted provider may initiate an appeal of a contract termination decision made by Regence through the Provider Contract Termination Appeal Process.

## 1. Level One Appeal

To request a Level One Appeal, you must send a written request to the Credentialing Department, at the address listed below within **thirty (30) business days** of receipt of the termination notification.

Provider Contract Termination Appeal - Level One  
*Attention: Credentialing Department*  
P.O. Box 21267, M/S S-555  
Seattle, WA 98111-3267

A request for an appeal regarding a contract termination must include, at a minimum:

- A detailed description of the disputed issue(s)
- The basis for your disagreement with the decision
- All evidence and documentation supporting your position  
(Exception: Please note that all documentation required to justify your billing, including, but not limited to, chart notes, to be present in your files at the time of an audit. Additions to file documentation or the production of files that were not made available to Regence at the time of an audit will not be considered in connection with an appeal involving adverse audit findings. We will, however, consider your explanation as to why the documentation was not present at the time of the audit.)
- Your requested outcome

Upon receipt of the Level One Appeal request, we will make our best efforts to send you an acknowledgement letter within **fifteen (15) business days**.

The Level One Appeal panel is comprised of the Regence Credentialing Committee, which includes employees and community-based providers. Voting members of the panel are limited to the community-based providers.

Level One Appeals meetings are held on a monthly basis. Your appeal will be scheduled for review at the next available Level One Appeal meeting, subject to the time your appeal request and any additional information are received and the volume of appeals being reviewed by the panel.

If additional information is requested, it must be submitted within **fifteen (15) business days** of the date of the written request for information, unless a written request for a reasonable extension of time is granted.

- If the information is not received on time, a decision will be made at the next Level One Appeal panel meeting, based on the limited information available.
- If the additional information is received on time, the new information will be taken into consideration at the next Level One Appeal panel meeting.

Information not submitted within the time limit will not be considered for the Level One Appeal, unless otherwise allowed by the Level One Appeal panel.

You will receive a written determination within **thirty (30) business days** of the Level One Appeal panel decision.

**The Level One Appeal decision is deemed final on the thirtieth (30<sup>th</sup>) business day after you receive it, unless a written request for a Level Two Appeal is received timely.**

## **2. Level Two Appeal – “In-Person Hearing”**

If you are not satisfied with the results of the Level One Appeal, you may submit a written request to the Credentialing Department, at the address listed below, for a Level Two Appeal, “in-person hearing” no later than **thirty (30) business days** after your receipt of the Level One Appeal decision.

Provider Contract Termination Appeal - Level Two  
*Attention: Credentialing Department*  
 P.O. Box 21267, M/S S-555  
 Seattle, WA 98111-3267

The Level Two Appeal panel is comprised of individuals affiliated with Regence that have not been directly involved in the Level One Appeal or the Credentialing Committee’s decision to terminate participation, and that have the appropriate level of knowledge or training to understand the issues presented. The Level Two Appeal panel must be comprised of at least three (3) voting members, and should include at least one (1) physician member, which shall be a Regence Medical Director.

The request for a Level Two Appeal must identify in detail the following:

- All issues on which you request re-evaluation
- Information not previously submitted to the Level One Appeal panel, if any (Exception: We expect all documentation required to justify your billing, including, but not limited to, chart notes, to be present in your files at the time of an audit. Additions to file documentation or the production of files that were not made available to Regence at the time of an audit will not be considered in connection with an appeal involving adverse audit findings. We will, however, consider your explanation as to why the documentation was not present at the time of the audit.)
- Your requested outcome

The hearing is generally completed within two (2) hours and will be scheduled for two (2) hours, unless you notify us when requesting your Level Two Appeal that additional time is needed. We will make our best efforts to accommodate reasonable requests for additional time, as long as we are notified when you request the Level Two Appeal.

Upon receipt of the Level Two Appeal request, we will make our best efforts to send you an acknowledgement letter within **fifteen (15) business days**, setting forth proposed times and dates for the Level Two Appeal hearing. We will make our best efforts to make the proposed times and dates within sixty (60) business days of the Company's receipt of your Level Two Appeal request. You will have five (5) business days from your receipt of the acknowledgement letter to notify us of your preferred time and date for the Level Two Appeal hearing. If you fail to notify us of your preferred time and date for the Level Two Appeal hearing within five (5) business days of your receipt of the acknowledgement letter, the hearing will be set on one of the proposed times and dates.

Prior to the Level Two Appeal hearing, you will receive a "**Notice of Hearing**". The "Notice of Hearing" will indicate the following:

- Date of the hearing
- Time of the hearing
- Location of the hearing
- Names of the members of the Level Two Appeal panel
- Reasons for the adverse action
- Names of witnesses who will testify on Regence's behalf at the hearing
- Your rights at the hearing

At the hearing, you have the following rights:

- To have representation by an attorney or other person of your choice
- To have a court reporter make a record of the proceedings at an additional cost to you. Costs associated with the court reporter must be paid by you prior to receiving a copy of the transcript
- To call witnesses and to examine/cross-examine witnesses
- To present relevant evidence (as determined by the panel)
- To submit a written statement at the close of the hearing

Approximately **thirty (30) calendar days** before the scheduled date of the hearing, a Level Two Appeal binder will be sent to you or your representative. The binder will include, among other things, the documentation reviewed by the Credentialing Committee initially and at the Level One Appeal, as well as any documentation submitted by you. If you wish to submit additional information to further supplement the Level Two Appeal binder, this information, as well as a list of witnesses that you plan to call, examine, and cross examine at the hearing, must be received no later than **fourteen (14) calendar days** prior to the hearing date. Unless otherwise allowed by the Level Two Appeal panel, documentation and witnesses not submitted at least **fourteen (14) calendar days** prior to the hearing date will not be considered by the Level Two Appeal panel and should not be brought to the hearing

for the panel's consideration. The only exception is that you may submit a written statement at the close of the hearing.

If the Level Two Appeal binder is later supplemented with new or revised information prior to the hearing, you will receive copies of the new or revised material as soon as practicable before the scheduled date of the hearing. After the Level Two Appeal binder has been finalized, it will be forwarded to the Level Two Appeal panel for review prior to the hearing. Neither you nor Regence may supplement the binder within thirteen (13) calendar days prior to the hearing, unless a written request for an exception is approved by the Chair of the Level Two Appeal panel.

You should receive written notification of the Level Two Appeal decision within **fifteen (15) business days** of the hearing. If the Level Two Appeal panel cannot reach a decision within **fifteen (15) business days**, or if additional information is needed to reach a decision, you will be informed of any additional information needed and a new date by which the decision will be made.

**Decisions of the Level Two Appeal panel related to contract terminations are deemed final. Once a decision has been made by the Level Two Appeal panel, you have completed the Provider Contract Termination Appeals process. If you are not satisfied with our decision after completing the Provider Contract Termination Appeal process and want to continue to dispute the issue(s), you must initiate the appropriate process(es) as outlined in your provider contract.**

### **3. Additional Information Regarding the Provider Contract Termination Appeals Process**

#### **a. Provider Status During a Contract Termination Appeal**

Generally, upon receipt of an appeal that meets the criteria outlined above, you will continue as a participating provider, and any pending action by Regence is put in abeyance until the appeal is resolved and a final decision is made. If, however, the basis for the termination decision relates to the health, safety or welfare of our members, or if we have exercised our right to immediately terminate the provider contract for reasons allowed by the provider contract, your participation status will be terminated for the duration of the appeal process and reinstated only if you prevail during the Provider Contract Termination Appeal process.

#### **b. HIPDB/NPDB Reportable Actions**

Regence is required by law to report certain adverse actions or decisions against you to the Health Care Integrity and Protection Data Bank (HIPDB) or the National Practitioner Data Bank (NPDB). The HIPDB requires us to report final adverse actions (e.g., contract terminations) that are based on acts or omissions that affect or could affect the payment, provision, or delivery of a health care item or service. These acts or omissions include, but

are not limited to, improper billing practices, substandard patient care and sexual misconduct.

The NPDB requires us to report actions that adversely affect the clinical privileges of a physician or dentist for a period longer than **thirty (30) days** and that are based on a physician's or dentist's professional competence or professional conduct that adversely affects, or could adversely affect, the health or welfare of a patient. Clinical privileges are privileges and other circumstances pertaining to the furnishing of medical care under which a physician, dentist or other licensed health care professionals is permitted to furnish care to members by us. Please note that we **must** report actions that meet the above criteria involving a physician or dentist. However, we **may** report such actions involving other health care professionals.

Contract terminations that meet the criteria for reportable terminations will be reported to the HIPDB or the NPDB after our decision has been deemed final either through exhaustion of the Provider Contract Termination Appeal process or through failure to submit a timely request for appeal. You may not "self-term" to avoid being reported to the HIPDB or the NPDB.

Please note that when we report a provider to a data bank, it is most often due to the reasons set forth above. However, there are other reasons we may report a provider to a data bank. Please see the HIPDB and NPDB regulations for more information. Additional information can be found at [www.npdb-hipdb.hrsa.gov/](http://www.npdb-hipdb.hrsa.gov/).

## **Regence Member Appeal Policy and Procedures**

The Regence Member Appeal Policy applies to all insured group and individual contracts issued by Regence Plans, with the exceptions of Federal Employee Program (FEP), Medicare beneficiaries, Medicaid and certain other government programs. The first two levels of regular appeal and the first level of Expedited Appeal procedures will apply to self-funded accounts unless otherwise agreed to by the Plan sponsor and the Regence Plan. An appeal must be initially submitted to the Regence Plan within 180 days of the member's receipt of the claim denial or other action giving rise to the complaint or grievance. Failure to initiate appeal within this time period (absent the Plan's finding, in its sole discretion, of acceptable extenuating circumstances) will preclude all further rights to appeal and may jeopardize the member's ability to contest the denial or other action in any forum. All applicable non-optional appeal levels must be exhausted before the member may contest the action in any forum, including through filing a lawsuit.

"Appeal" includes any grievance, complaint, reconsideration or similar terms as used in some jurisdictions, and is a written or oral request from a member, their personal representative, treating provider or appeal representative, to change a previous decision (Adverse Benefit Determination) made by the Regence Plan concerning:

- a. access to health care benefits, including an adverse determination made pursuant to utilization review;
- b. claims payment, handling or reimbursement for health care services;
- c. matters pertaining to the contractual relationship between a member and the Plan; or
- d. other matters as specifically required by law or regulation.

“Appeal representative” is a representative of the member for the purpose of the appeal. The appeal representative may be the member’s personal representative, a treating provider, or another party, such as a family member, for whom the member or their personal representative has signed a valid authorization. If no such authorization exists and is not received in the course of the appeal, the determination and any personal information will be disclosed to the member, their personal representative or treating provider only.

“Personal representative” means a person who is legally authorized to act on behalf of an individual for health care decisions. For example: parents of a minor; a person holding a power of attorney; conservator; or person appointed by a court; so long as the power granted to the person includes managing the individual’s health care affairs.

“Authorization” is an individual’s written permission for use and disclosure of their personal information for a specific purpose and timeframe in accordance with the Regence Privacy Policy.

“Adverse benefits determination” means any of the following; a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of any of the following:

- a. eligibility to participate in a plan
- b. application of utilization review
- c. determination that a treatment is experimental or investigational
- d. determination that a treatment is not medically necessary or
- e. contractual exclusion or limitation

“Urgent care request” is any pre-service or concurrent care claim for medical care or treatment for which the application of the time periods for making regular appeal determinations:

- a. could seriously jeopardize the life or health of the member or the ability of the member to regain maximum function or
- b. in the opinion of a physician with knowledge of the member’s medical condition, would subject the member to severe pain that cannot be adequately managed without the disputed care or treatment.

An individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may determine whether a request is an urgent care request. However, the determination by a physician with knowledge of the member’s medical condition that a request is an urgent care request is binding.

Regence members are entitled to three levels of review. At any time during the process, members may file a complaint with the Department of Consumer and Business Services:

Oregon Insurance Division; Consumer Protection  
Unit 350 Winter Street NE, Room 440-2  
Salem, OR 97310

Washington-based members (Clark County) may file a complaint with the Washington Office of Insurance Commissioner:

P.O. Box 40256  
Olympia, WA 98504-0256  
FAX: (360) 586 2018

### **Level One Appeal – Grievance, Complaint, Reconsideration**

The member or member representative has the right to request an appeal within 180 days of receipt of the written notification of an adverse benefit determination. If a member chooses to file an appeal, Customer Service will provide assistance to the member by accepting information about the member's appeal over the phone or will provide the member with a form for a written appeal.

A Customer Service grievance coordinator will acknowledge receipt of the appeal, advise the member of all member rights and gather the necessary information to thoroughly investigate the issue. Upon completion of the review, the grievance coordinator will send a written response to the member. Appeals involving pre-service issues are responded to within 14 calendar days; investigational post-service issues are responded to within 20 working days; and other post-service issues are responded to within 30 calendar days. Expedited reviews are responded to within 72 hours from the receipt of the request. If the decision is not in the member's favor, the member or member representative will be informed of their right to further appeal.

### **Level Two**

The member or member representative may file a Level Two appeal. Requests for a Level Two appeal must be submitted within 180 days of the receipt of an adverse determination at the first level. The member or member's representative may appear before the member appeal panel at this level of review. The appeal coordinator/specialist acknowledges the receipt of the appeal by the fifth working or seventh calendar day. The acknowledgement must be in writing and must state all member rights. Documentation is compiled by the appeal coordinator/specialist then presented to an internal appeal panel. The panel is comprised of three voting members not previously involved with the case. A written response is sent to the member in:

- Fourteen days for pre-service issues
- Twenty working days for post-service investigational procedures
- Thirty days for all other appeals

If the decision is not in the member's favor, the member is informed of the next level of appeal and again informed of their right to file a complaint with the Oregon Insurance Division or the Washington Insurance Division (members residing in Clark County). For issues related to medical necessity, investigational services or supplies, or continuity of care, the member is informed of the right to file the appeal with an Independent Review Organization (IRO) within 180 days. For all other issues, the member is informed of their right to file a final appeal to be considered by another internal three-member panel.

### **Level Three Appeals**

The State of Oregon is notified of the request for external appeal within two working days of receipt. They will assign an Independent Review Organization (IRO) to the request by the next business day. The appeal, including all documentation, will be delivered to the IRO no later than the sixth business day after notice of the assignment by the state.

An IRO is an independent organization employing physicians and other medically-qualified individuals or experts, which acts as the decision maker for external appeals (regular or expedited), either through an independent contractor relationship with the Plan, and/or through assignment to the Plan via state regulatory requirements.

The IRO will provide to the member and/or appeal representative in writing:

- the decision by the IRO
- a list of the IRO reviewer title(s) and qualifications
- a full description of the IRO's rationale

Regence agrees to be bound by the decision of the IRO.

### **Level Three Internal Appeal**

All benefit administration appeals are handled through a third level internal review panel. The member or their representative has the right to appear in person at this level of review. Documentation is compiled by the appeal coordinator/specialist and presented to an internal appeal panel. The panel is comprised of representatives not involved in prior decisions. A written response is sent to the member or member representative within 14 days for pre-service appeals or 30 days for post-service appeals. Our response will remind the member that they may also file a complaint with the Oregon Insurance Division or the Washington Insurance Division (members residing in Clark County).

## **Expedited Appeals**

An expedited appeal may be requested if:

- the member or the member's physician reasonably believes that the application of time periods for making regular appeal determinations for a pre-service or concurrent issue could jeopardize the member's life, health or ability to regain maximum function
- a physician with knowledge of the member's medical condition reasonably believes that the application of time periods for making regular appeal determinations for a pre-service or concurrent care issue could subject the member to severe pain that cannot be adequately managed without the disputed care or treatment.

The member, their representative or the physician may request an expedited appeal either verbally or in writing. The member, provider or member representative may provide additional written documentation and may attend by telephone.

Expedited appeals are responded to within 72 hours by telephone, facsimile or other available similarly expeditious methods. Written notification follows.

As a participating physician, you can minimize the complaints and appeals by:

- Acknowledging and upholding members' right to complaints, grievances and appeals
- Explaining these rights to members who contact you to express a concern or dissatisfaction
- Assisting Regence in timely resolution by submitting requested records or input within seven days of the request

## **Member Rights and Responsibilities**

Regence is committed to providing our members with the best possible health care coverage. Members are entitled to be treated in a manner that respects their rights and addresses their responsibilities.

Providing the best possible health care coverage requires more than comprehensive benefit packages, prompt claims processing and efficient customer service. It also includes notifying our members of their rights and responsibilities and conscientiously protecting these rights. Therefore, we have developed a written policy that addresses members' rights and responsibilities. This policy is revised based on regulatory requirements for entities such as: Centers for Medicare & Medicaid Services (CMS) and Federal and State Patient Protection Acts.

Each individual within the health plan is responsible for protecting these rights. Our participating physicians, other health care professionals and facilities are also contractually obligated to preserve and respect these rights.

## **Rights for Members Enrolled in Commercial Group Plans**

Subscribers and their enrolled dependents have the right to make their own health care decisions. Although we must set guidelines that affect how benefits are paid, these guidelines merely dictate whether the cost of care is eligible for reimbursement.

Members of Regence have the right to:

### ***Timely and Quality Care***

- timely access to their physicians and other health care professionals and referrals to specialists when medically necessary
- continuity of care and to know in advance the time and location of an appointment, as well as the physicians and other health care professionals providing care
- receive the medical care that is necessary for the proper diagnosis and treatment of any covered illness or injury
- have their physicians and health care professionals tell them about their diagnosis, the prognosis of their condition, and instructions required for follow-up care
- participate with physicians and health care professionals in decision-making regarding their health care and treatment planning;
- a candid discussion of appropriate or medically necessary treatment options for their condition, regardless of cost or benefit coverage

### ***Treatment with Dignity and Respect***

- be treated with respect, dignity, compassion and the right to privacy
- exercise these rights regardless of race, physical or mental ability, ethnicity, gender, sexual orientation, creed, age, religion or their national origin, cultural or educational background, economic or health status, English proficiency, reading skills, or source of payment for their care. Expect these rights by both the Plan and contracting physicians.
- expect consideration of privacy concerning their care and confidentiality in all communications and in their medical records
- extend their rights to any person who may have legal responsibility to make decisions on their behalf regarding their medical care
- know why they are given various tests, treatments or procedures, who provides them, and the risks of any procedure or treatment
- refuse treatment and to be informed of the medical consequences of this action
- refuse to sign a consent form if they feel they do not clearly understand its purpose, or cross out any part of the form they do not want applied to their care, or change their mind about any treatment for which they have previously given consent
- be informed of policies regarding Advance Directives (living wills) as required by state and federal laws

### ***Health Plan and Other Important Information***

- receive information about their health plan, its services, its physicians, other health care professionals, facilities, clinical guidelines and member rights and responsibilities statements

- expect a clear explanation regarding benefits and exclusions of their policy
- know by name the physicians, nurses, or other health care professionals providing care
- information about medications – what they are, how to take them and possible side effects
- information regarding how medical treatment decisions are made by the health plan or contracted medical groups, including payment structure
- be advised if a practitioner proposes to engage in experimentation affecting care or treatment. They have the right to refuse or participate in such research projects

### ***Solving Problems in a Timely Fashion***

- present questions, concerns or complaints to a customer service specialist without discrimination and expect problems to be fairly examined and appropriately addressed
- voice a complaint about their health plan or the care provided including the right to appeal an action or a denial, and the process involved
- make recommendations regarding the health plan members' rights and responsibilities policies

## **Responsibilities for Members Enrolled in Commercial Group Plans**

In addition to their rights, subscribers and their enrolled dependents have the responsibility to:

- identify themselves as a Regence enrollee and present their identification card when requesting health care services
- be on time for appointments and contact the physician or other health care professional at once if there is a need to cancel or if they are going to be late for an appointment; if the physician, other health care professional or facility has a policy for assessing charges regarding late cancellations or “no shows,” they will be responsible for such charges
- provide, to the extent possible, information about their health to physicians and other health care professionals so they may provide appropriate care
- do their part to improve their health condition by following the plans, instructions, and care that they agreed upon with the physician or health care professional
- act in a manner that supports the care provided to other patients and the general functioning of the office or facility
- to participate, to the degree possible, in understanding their behavioral health problems and developing mutually agreed upon treatment goals
- review their employee benefit booklet to make sure services are covered under the plan
- follow Plan requirements to have services properly authorized before receiving medical attention
- to participate, to the degree possible, in understanding their health problems including behavioral health, and developing mutually agreed upon treatment goals
- inform Customer Service if they feel they or their family members are not receiving adequate care
- check their benefit booklet and follow proper procedures for illness after business hours

- review information and materials concerning health benefits and educate other covered family members
- provide identification cards to family members to be presented at the time of service
- accept the financial responsibility for any co-payment or coinsurance associated with services received while under the care of a physician or other health care professional or while a patient at a facility
- let us know if they have concerns, or if they feel their rights are being compromised so we may act on their behalf