Member Grievances and Appeals Process

Introduction

The Anthem Blue Cross Member grievances and appeals process offers Members, their authorized representatives, health care Providers and Facilities acting on behalf of Members the right to request a formal appeal evaluation of any denial issued by Anthem Blue Cross. Anthem. Blue Cross must comply with current federal and state regulations and accreditation performance standards (e.g., NCQA) that apply to processing Member grievances and appeals. Anthem Blue Cross must ensure that internal review processes are fair and impartial.

The Anthem Blue Cross Grievances and Appeals (G&A) Department administers the formal grievances and appeals process. G&A is responsible for ensuring a consistent procedure for documenting, investigating, resolving, and responding to Member issues in a timely and accurate manner. The Anthem Blue Cross Behavioral Health (BH) G&A Department is responsible for addressing Member grievances and appeals related to behavioral health care services and treatment. The term "G&A" used throughout this section refers to both Medical G&A and BH G&A, unless otherwise specified.

Anthem Blue Cross and some Anthem Blue Cross Life and Health plans require Members to file an appeal or grievance with us no later than 180 days following the date they received a denial notice or the date of an incident or dispute. G&A will follow the timeframe limit that is specified in the G&A Member's Evidence of Coverage (EOC) or Summary Plan Description (SPD). If the date of the last denial notice or the date of the incident or dispute cannot be determined, G&A will proceed with the appeal or grievance review as filed. If a party responds with a written explanation showing good cause for missing the required timeframe, G&A will consider the circumstances that kept the Member from making the request on time and whether organizational actions might have misled the Member. Exceptions are made for good cause.

Member Grievance Process and Terms Must Be Made Available at Provider/Facility's Office

Section 28 CCR 1300.68(b)(6) and (7) of the Knox Keene Act and Regulations requires Health Plans to require that Member grievance forms and a description of grievance procedures are readily available at each contracted Provider's office or facility. Grievance forms must be provided by the Provider to the Member upon request.

The Member grievance form to be available for each location of your participating office or facility, is found in the Exhibits section of this Manual. It is important to implement processes to provide grievance forms and a description of Anthem's grievance procedures to Anthem Members promptly upon request.

Your agreement with Anthem requires you to comply with all applicable laws and regulations which includes an obligation to cooperate with Anthem's administration of its grievance program.

Additional information can be accessed on the process of submitting member grievances and appeals, grievance forms, definitions and appeal rights, on Anthem's website at www.anthem.com/ca/forms. Go to View by Topic and click on the drop down menu and select Grievance & Appeals, then select the desired resource link

Member Representation

The appeal process provides for a Member, Member's authorized representative, and health care Provider or Facility rendering care, acting on behalf of a Member, to submit a verbal or written appeal to Anthem Blue Cross. Members may choose anyone they wish to represent them, at any level of the appeal process, including an attorney.

A signed designation of representative form (DOR) is not required when the Member's practitioner, acting on behalf of the Member, submits a pre-service or concurrent appeal. If a Member is a minor, or is incompetent or incapacitated, then the parent, guardian, conservator, relative or other designee of the Member, with supporting legal documentation, such as guardianship papers, health care power of attorney, or other appropriate documents, may submit the appeal.

For the purposes of this section, the term "Member" will refer to the Member, designated representative or health care Provider/ Facility acting on behalf of the Member. G&A follows HIPAA privacy standards to ensure Member, medical record and data confidentiality.

Right to Submit Additional Information During Appeals Process

Members have the right to submit written comments, documents and other information related to the appeal request. This information will be accepted and taken into account during the appeal review even when such information was available and considered during the initial review. G&A will conduct a review of the appeal that does not give deference to the initial denial. G&A will fully investigate the content of the appeal, including all aspects of clinical care involved, and document its findings.

Formal grievance/appeal policies and procedures are available to the Member, the health care Provider and the Facility rendering care, upon request.

Custodial Parent Rights

In accordance with California Health and Safety Code requirements, a non-covered custodial parent (evidenced by a court or administrative order) of a covered minor is entitled to receive copies of the same correspondence sent to our Subscriber, the non-custodial parent. However, the custodial parent will not be notified in any cases where there are clear clinical and/or legal reasons in which potential harm could come to the minor as a result of such notification (such as in cases of family violence or abuse).

Members With Linguistic and Cultural Needs, Limited English Proficiency, and Other Communicative Impairments or Disabilities

The Anthem Blue Cross grievance/appeal process is designed to serve the linguistic and cultural needs of its Member population, as well as the needs of Members with disabilities. G&A shall ensure that all Members have access to, and can fully participate in, the grievance system by providing assistance for those who speak a language other than English, have limited English proficiency, or have a hearing impairment or other communicative impairment. Such assistance includes translation of grievance procedures, forms, and plan responses to grievances, as well as access to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate. G&A associates are trained to ensure that Members, who submit oral or written grievances and appeals in a language other than English, are sent responses in the same language as the Member submitted.

Background Information

The California Department of Managed Health Care (DMHC) regulates managed health care HMO/POS/PPO plans and Medicare Supplement business. The California Department of Insurance (CDI) regulates Anthem Blue Cross Life and Health Insurance Company plans and Medicare Supplement business in California. Centers for Medicare & Medicaid Services (CMS) regulates Anthem Blue Cross Medicare Advantage and Medicare Supplement business in California. Under applicable law and regulations, the DMHC requires that every managed care health plan establish and maintain a grievance system through which Members may submit grievances to the plan.

Definitions

For the purposes of this section, the term "Member" will refer to the Member, designated representative or health care Provider/ Facility acting on behalf of the Member. G&A follows HIPAA privacy standards to ensure Member, medical record and data confidentiality.

Grievance is a written or oral expression of dissatisfaction regarding the plan and/or Provider, including quality-of-care concerns, and shall include a complaint, dispute, request for reconsideration, or appeal made by a Member or the Member's representative. When the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

Appeal is a formal request for reconsideration or reversal of an adverse determination (denial) made by Anthem Blue Cross.

Benefit Appeal pertains to the denial of a health care service substantially based on a finding that the particular service is excluded as a benefit under the terms and conditions of the Member's benefit plan.

Prudent Layperson is a person who is without medical training and who draws on his or her practical experience when making a decision regarding the need to seek emergency medical treatment.

Same Specialist refers to a practitioner with similar credentials and licensure as those who typically treat the condition or health problem in question in the appeal.

Similar Specialist refers to a practitioner who has experience treating the same problems as those in question in the appeal, in addition to experience treating similar complications of those problems.

G&A Staff and Scope of Responsibility G&A is comprised of a team of board-certified physicians (medical directors), nurses, behavioral health clinicians, and G&A analysts and Behavioral Health (BH) coordinators trained in the G&A process. The G&A team is charged with resolving Member grievances and appeals through an equitable, timely and consistent process, and communicating resolutions in a clear, concise manner.

The Anthem Blue Cross Grievances and Appeals Officer has primary responsibility for the Anthem Blue Cross grievances and appeals process and monitors the operation of the system on a continuous basis to identify any emergent patterns of grievances/ appeals. This individual is also responsible for ensuring compliance with reporting requirements.

The Grievances and Appeals Medical Directors are board-certified physicians in a variety of specialties, with current and active, unrestricted medical licenses. The medical directors are responsible for clinical review, oversight and final decision-making on quality-of-care grievances, Medical Necessity and investigational appeals. The medical director or his designee making the final decision on an appeal is an individual who did not participate in any prior review and is not a subordinate of any previous reviewer and will not have participated in the initial denial. All appeals involving Medical Necessity and investigational treatment are reviewed by a peer clinical reviewer (PCR) in the same or similar specialty as the area of care under review.

Peer Clinical Reviewers (PCRs) are health care professionals with current and active unrestricted licenses to practice medicine and are board certified by a specialty board approved by the American Board of Medical Specialists (doctors of medicine) or the Advisory Board of Osteopathic Specialists (doctor of osteopathic medicine). PCRs who participate in the review of clinical appeals must be in the same or similar specialty that typically manages the medical condition, procedure or treatment under review. They render expert opinions and recommendations on clinical issues.

Grievances and Appeals Clinical Staff includes licensed nurses and licensed behavioral health clinicians, who coordinate the review and investigation of clinical grievances.

Grievances and Appeals Analysts are non-clinical staff responsible for the review and resolution of administrative aspects of grievances and appeals.

Grievances and Appeals Clinical Associates, Behavioral Health Clinicians and an Audit Team handle special projects and tasks including, but not limited to, the following:

- Investigating and responding to Member regulatory complaints, and regulators' request for information/records to facilitate the Independent Medical Review (IMR) process
- Training and mentoring G&A associates on all aspects of the grievance and appeals process, including changes in regulatory and accreditation standards as applicable, and correct usage of the G&A database documentation system.

- Ensuring that G&A policies and procedures are compliant with regulatory and accreditation standards, and educating staff of any policy changes that affect the processing of grievances/appeals
- Internal audits of G&A cases to ensure compliance
- Coordination of review of cases referred to the Anthem Blue Cross Peer Review or Credentialing Committees and recording minutes of the meetings
- Trend analysis of grievances and reporting results to the designated medical director

Commercial Plans

Initial Determination Process and Denial Notification Procedures

The initial decision to approve or deny requests for prospective, concurrent or retrospective health care services is made by Anthem Blue Cross (for certain types of health care services) for Members enrolled in PPO plans. If Anthem Blue Cross denies a requested health care service or claim, Members and their Providers are sent written notification of the denial and a description of appeal rights.

Process for Submitting Member Grievances and Appeals to Anthem

Members may request a grievance or appeal regarding any denial of authorization resulting from a request for a prospective, concurrent or retrospective review of health care service. Member grievances and appeals may be submitted in writing or verbally. Members and their representatives also have the option of submitting grievances/appeals online to Anthem Blue Cross via the Internet. The grievance website is accessed at anthem.com/ca. Grievance forms are posted in both Spanish and English on the website. The completed grievance form is then routed to the Customer Service Inquiry Tracking System for distribution to the appropriate G&A area. The Member may also print the form, complete it, and send it to Anthem Blue Cross at the address below.

Grievances or appeals received verbally by the Customer Service Unit are documented on the Customer Service Inquiry Tracking System and routed to the G&A unit for investigation and resolution. Grievances or appeals received verbally by the Utilization Management (UM) Department are documented in a clinical documentation system and routed to the appropriate G&A unit.

The Member or Member's representative should document the circumstances surrounding the grievance/appeal and submit this information along with any available medical documents, including medical records or claims to Anthem Blue Cross. Members may refer to their EOC or contact Anthem Blue Cross Customer Service for further information on the G&A process. Members may submit a grievance and/or appeal in writing to G&A at the following address:

Anthem Blue Cross
P.O. Box 4310 Woodland Hills, CA 91365-4310
Fax: 818-234-1089

For FEP PPO, please use the following address for professional inquiries:

Blue Shield of California
P.O. Box 272510 Chico, CA 95927
Phone: 800-824-8839

Medicare Advantage Members may submit a grievance and/or appeal in writing to Medicare G&A at the following address:

Anthem Blue Cross
Medicare Complaints Grievances and Appeals Department 4361 Irwin Simpson Rd – OH0102-C535
Mason, OH 45040

Acknowledgement and Investigation of Appeals

Grievances and appeals are acknowledged in writing within five calendar days of the health plan receipt date. The acknowledgement letter contains the following information:

a. The date the grievance was received by the health plan
b. A general explanation of the grievance process and timeframe
c. The name, address and phone number of the health plan representative who may be contacted about the grievance
d. A statement that the Member may submit additional written comments, documents or other information in support of the grievance
e. Plans regulated by the California DMHC must include the DMHC's toll-free telephone number, California Relay Services' telephone number, and the DMHC's Internet address in 12-point boldface font Anthem Blue Cross will obtain the necessary medical information used in the initial denial, as well as additional medical information from the Provider, as appropriate. When a request for information is sent, the Provider is required to respond within seven to 10 calendar days of the request, or sooner depending on the clinical urgency of the case.

Members have a right to review their appeal file, present evidence during the appeals process and continue to receive coverage pending the outcome.

The appropriate administrative and/or clinical specialists will review the case, including any additional supporting information received. The individual(s) reviewing the appeal will not have participated in the original decision, and will not be a subordinate of the individual who made the original decision.

After Anthem Blue Cross has completed its review, a written statement of its resolution is sent to the Member and Provider within 30 calendar days of receiving the grievance/appeal. Appeal denial letters provide the rationale and criteria used in the decision and additional dispute resolution rights as stated in the Member's EOC, including the right to request an independent medical review (IMR), as applicable.

Members have a right to request a copy of the criteria used in the decision, as well as copies of relevant documents and records relied on in the appeal review. There is no charge to the Member for this information. Members may request this information by calling G&A at800-365-0609 or the TDD line at 866-333-4823 for the speech and hearing impaired.

A written request for information should be mailed to:

Anthem Blue Cross
P.O. Box 4310 Woodland Hills, CA 91365-4310

For FEP PPO, please use the following address/phone number:

Blue Shield of California
P.O. Box 272510 Chico, CA 95927
Phone: 800-824-8839

Expedited Appeals

Members or their representatives have the right to request an expedited appeal. Expedited appeals are cases involving an imminent and serious threat to the health of the Member including, but not limited to, severe pain, potential loss of life, limb or major bodily function. An expedited appeal review will automatically apply to inpatient admissions and continued stays, including health care services for Members who remain inpatient in a Facility after receiving emergency care.

When a grievance or appeal meets expedited criteria, Anthem Blue Cross must immediately notify the Member of his or her right to request assistance from the DMHC, as applicable to the Member's plan, and provide the Member with the DMHC's toll-free number and TDD line.

Members are not required to participate in Anthem Blue Cross' expedited grievance or appeal process, prior to contacting the DMHC for assistance.

When an appeal is expedited, all necessary medical information is gathered to make a determination. As needed, the Provider will be asked to submit medical records to Anthem Blue Cross within 24 hours of the request. Expedited appeals must be resolved within 72 hours of the Anthem Blue Cross receipt date. The Member is notified verbally and the Provider is notified verbally of the decision within 72 hours of the plan receipt date. Verbal notification is followed by written notification within three calendar days of receipt. The written notice will include the decision, rationale, applicable review criteria used in the decision

and, if denied, a description of further dispute resolution options, which may include the right to request an IMR.
If the appeal request does not meet the criteria for an expedited review, the Member and Provider/practitioner are notified in writing within 72 hours of the request. The letter provides the reason for not expediting the appeal and explains the standard appeal process, including the 30- calendar day resolution timeframe. The medical record should be submitted for the appeal.

See the section of this Manual titled **Clinical Appeals** for additional information on member appeals involving medical necessity or experimental/investigational issues