2.35 Medical Necessity Appeals

Medical necessity appeals apply to authorization requests that were denied prior to the service or authorization concurrent requests made during an inpatient hospital confinement. Medical necessity appeals/prior authorization appeals are different than claim payment disputes and should be submitted in accordance with the medical necessity appeal process.

If you are required to obtain prior authorization on a concurrent or post-service basis, the consent of the Member who received the services will not be required in order for you to dispute the denied authorization for service.

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Healthy Blue will ensure that members, and authorized representatives acting on behalf of the member, have a full and fair process for resolving requests to reconsider a decision they find unacceptable regarding denial of prior authorization.

A member will have a reasonable opportunity to present evidence — submit written comments, documents, records and other information relevant to the appeal along with allegations of fact or law — in person as well as in writing.

Healthy Blue also ensures the member and his or her representative are provided the opportunity before and during the appeal process to examine the member's case file (including medical records), and any other documents and records considered during the appeal process. This includes any evidence considered, relied upon or generated by Healthy Blue in connection with the appeal. This information is provided free of charge and sufficiently in advance of the date by which we resolve the appeal.

Our goal is to handle and resolve every appeal as quickly as the member's health condition requires. Our established time frames are as follows:

- Standard resolution of appeal: thirty calendar days from the date of receipt of the appeal
- Expedited resolution of appeal: seventy-two hours from receipt of the appeal
    - We make every reasonable effort to give the member or his or her representative oral notification and then follow it up with a written notification.

The member, or the member's representative, can file an appeal within 60 calendar days from the date on the Healthy Blue Notice of Action. A provider may file an appeal on behalf of the member. The provider must follow all requirements for a member appeal, including timely filing of the written request for appeal.

We will inform the member of the limited time he or she has to present evidence and allegations of fact or law with expedited resolution. And we also ensure that no punitive action will be taken against a provider who supports an expedited appeal.

We will send our members the results of the resolution in a written notice within 30 calendar days of receipt of the appeal. If an appeal is not wholly resolved in favor of the member, the notice will include:

- The right for our member to request a state fair hearing and how to do it.
- The right to receive benefits while this hearing is pending and how to request it.
- Notice that the member may have to pay the cost of these benefits if the state fair hearing officer upholds the Healthy Blue action.

7.4 Provider Claim Payment Disputes

If you disagree with the outcome of a claim, you may begin the Healthy Blue provider payment dispute process. The simplest way to define a claim payment dispute is when the claim is finalized but you disagree with the outcome.

In cases where your claim is denied, the consent of a Member who received the services is not required in order for you to dispute the denial of the claim. You may pursue a claim dispute on the basis of non-payment for rendered services under the terms and conditions outlined in you contract with Healthy Blue. The Member who received the services is not required to sign an authorized representative form, or provide other forms of written consent, for you to dispute the denied claim for payment.

A claim payment dispute may be submitted for multiple reason(s) including:

- Contractual payment issues.
- Inappropriate or unapproved referrals initiated by providers.
- Retrospective review.
- Disagreements over reduced or zero-paid claims.
- Other health insurance denial issues.
- Claim code editing issues.
- Duplicate claim issues.
- Experimental/investigational procedure issues.
- Claim data issues.
- Timely filing issues.*

* Healthy Blue will consider reimbursement of a claim that has been denied due to failure to meet timely filing if you can: 1) provide documentation the claim was submitted within the timely filing requirements or 2) demonstrate good cause exists.

Please be aware, there are three common, claim-related issues that are not considered claim payment disputes. To avoid confusion with claim payment disputes, these are briefly defined below. They are:

- **Claim inquiry:** A question about a claim, but not a request to change a claim payment (see the Claim Inquiry section for more information).
- **Claims correspondence:** When Healthy Blue requests further information to finalize a claim. Typically, these requests include medical records, itemized bills or information about other insurance a member may have. A full list of correspondence-related materials are in the Claim Correspondence section of this provider manual.
- **Medical necessity appeal:** A preservice appeal for a denied service. For these, a claim has not yet been submitted (see the Medical Necessity Appeals section for more information).

The Healthy Blue provider payment dispute process consists of two internal steps. Additionally, there are two external options. You will not be penalized for filing a claim payment dispute, and no action is required by the member.

1. **Claim payment reconsideration:** This is the first step in the Healthy Blue provider payment dispute process. The reconsideration represents your initial request for an investigation into the outcome of the claim. Most issues are resolved at the claim payment reconsideration step.
2. **Claim payment appeal:** This is the second step in the Healthy Blue provider payment dispute process. If you disagree with the outcome of the reconsideration, you may request an additional review as a claim payment appeal.
3. **Independent review:** This external review process was established by LA-RS 46:460.81, et seg. To resolve claims disputed when a provider believes an MCO has denied claims incorrectly in part or in full.

4. **Binding arbitration:** The state of Louisiana supports an external arbitrator review process if you have exhausted all steps in the Healthy Blue payment dispute process but still disagree with the outcome.