|  |  |  |
| --- | --- | --- |
| Utilization Management Program: Appeal of Non-Certifications | |  |
|  |  | | |

**Appeals Process**

The Payer Compass Utilization Review Department assumes the following responsibilities during the appeals process:

* Provide the patient, health care provider, and/or patient representative with a formal process for responding to an adverse determination regarding non-certifications.
* Facilitate continued quality of care by resolving all requests for reconsideration, standard appeals, and expedited appeals.
* Ensure that a clinical peer makes all appeal decisions.

### The following outlines the Appeals procedure:

### Standard and Expedited Appeal Requests

The Payer Compass Utilization Review Nurse shall provide written appeal policies and procedures upon request to any patient, provider, or facility rendering the service.

The Payer Compass Utilization Review Nurse shall offer the patient, provider, or facility rendering the service the opportunity to provide written comments, documents, records, and other information relating to the case by telephone, voicemail, facsimile, email, mailed letter, or website.

All information submitted will be considered during the appeals process regardless of whether this information was submitted or considered initially.

In first level appeals, the Payer Compass Utilization Review Nurse implements the decision of the first level clinical appeal if it overturns the initial non-certification.

1. All appeals will be referred to a URAC accredited Independent Review Organization (IRO) provider who has the following qualifications:

* An unrestricted license to practice in a US state or territory
* An applicable board certification
* Same state licensure
* Same specialty reviewer
* Not involved in the non-certification determination

1. The IRO provider will be provided the following information:

* All records used in making the initial non-certification determination
* The physician report recommending non-certification
* All additional records submitted with the appeal request, if applicable
* Pertinent Medical Benefit Plan language may be included
* The timeframe for completing the review

1. The written notification of the decision to uphold the Non-Certification shall include:

* The principal reasons for the determination
* The instructions for requesting the written clinical rationale
* The instructions for initiating the next level of appeal (if available)

1. In each appeal case, the reviewer shall attest to:

* Having a scope of licensure or certification that typically manages the medical condition, procedure, treatment, or issue under review
* Current relevant experience and/or knowledge to render a determination for the case under review.

1. Payer Compass will provide the member the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793 to assist individuals with internal claims and appeals and external review processes.

### Standard Appeal Requests

If the ordering physician/provider is notified of the decision to not certify a service and disagrees with this decision, an appeal of this determination can be requested. The Payer Compass Utilization Review Nurse shall inform the provider of the option to have a Peer-to-Peer Review (if not already completed) and an expedited appeal. (See Peer-to-Peer Denial of Authorization Requests Policy.)

The standard appeal shall be completed within 30 calendar days from receipt of the appeal request.

Written notification of the appeal decision issued will be provided to the patient and ordering physician/provider or facility rendering the services.

### Expedited Appeal Requests

If the ordering physician/provider is notified of the decision to not certify a service and disagrees with this decision, an expedited appeal of this determination can be requested. The Payer Compass Utilization Review Nurse shall inform the provider of the option to have a Peer-to-Peer Review (if not already completed) and an expedited appeal.

The expedited appeal shall be completed within 72 hours of the request with verbal notification of the decision to the ordering physician/provider or facility rendering the service.

Written confirmation of the decision will be provided within 3 calendar days to the patient and the ordering physician/provider and facility rendering the services.