# Utilization Management Policy for Appeals

**Purpose:**

To provide a consistent plan for thorough, appropriate and timely resolution of member appeals, including preservice, postservice, expedited and external appeals.

**Definitions:**

An appeal is a request to change an adverse decision made by the organization. A member or the member's authorized representative may appeal an adverse decision. Appeals may be requested for a denial of claims, denial of benefit, rescission of coverage or other denial or modification of coverage. Appeals may also be applicable for some complaints when a member receives an adverse decision. See Grievances/Complaints and Appeals document for further information on these latter circumstances.

A preservice appeal is a request to change an adverse determination for care or services that the Plan must approve in advance of the member obtaining care or services.

A postservice appeal is a request to change an adverse determination for care or services that have already been received by the member.

An expedited appeal is a request to change an adverse determination for urgent care. Urgent care/request is a request for medical care or services/treatment where application of the time frame for making routine or non-life threatening care determinations:

- Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a person who reasonably believed that an emergency medical condition existed, ***or***
- Could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, ***or***
- In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

An external appeal is a request for an independent, external review of the final adverse determination made by the Plan through its internal appeal process.

**Guidelines:**

Members have the right to request appeals regarding modified or denied benefits and services. Ventura County Health Care Plan (VCHCP), it's Plan Providers and Facilities will not discriminate against members who have chosen to file an appeal. The fact that a member submits an appeal to VCHCP will not affect in any way the manner in which the member is treated by VCHCP or receives services from contracting providers. If VCHCP discovers that any improper action has been taken against such a member, immediate steps will be taken to rectify the situation and prevent such conduct in the future.

Enrollees are encouraged to review VCHCP's benefits and exclusions carefully prior to selecting our benefit Plan for their health care needs. Certain health care services, for example, purely cosmetic surgery, are not covered benefits of the Plan. Services, medications, devices, or procedures that do not represent approved medical practices are also excluded from coverage by VCHCP. All such determinations for coverage are made by the Medical Director of the Plan.

The Plan does not rescind coverage with respect to an individual once the individual is covered, except in the case of an act, practice or omission that constitutes fraud, or an intentional misrepresentation of material fact as prohibited by the terms of the coverage.

VCHCP documents research, interim and final responses to the Member in a fair and timely manner.

Members, member's legal guardian, conservator, relative or physician may submit an appeal.

With the exception of denials based on limitations or conditions contained in the Evidence of Coverage (EOC), only a licensed physician or other licensed health care professional who is competent to evaluate the specific clinical issues can modify or deny requests for services. Appeals are reviewed by a licensed physician, with appropriate expertise, who was not involved with the original decision and is not a subordinate of such individual.

A physician reviewer is available to physicians to conduct telephone discussions regarding the determinations that are made based on medical appropriateness.

An external independent medical review process is in place for members disputing a final determination made by the Plan through its internal appeal process. (See External Independent Medical Review Process/DMHC document for details.)

An external medical review process is in place for cases involving such issues as new technology, new usage of prior technology, potential experimental or investigational protocol or uncertain effectiveness of a treatment. (See External Independent Medical Review Process/IRO document for details.)

The Plan has procedures in place that allow members to have continued coverage under their medical benefit pending the outcome of an internal appeal.

**Procedure for Processing Appeals:**

**Preservice and Postservice**

With all Plan actions taken on requested services, including approvals, modifications and denials, written notification is sent to members via mail and to providers via fax, unless no fax is available, then it is sent by mail. Denial letters include the reason for the denial and the specific Utilization Management (UM) criteria or benefits interpretation, along with the application of that information to the specific patient. This notification also explains the member's appeal rights and procedure for appeals, including the right to submit written comments, documents or other information relating to the appeal and the ability to obtain specific criteria upon request. Members have the opportunity to submit information relevant to the appeal. If the member fails to submit relevant information by the specified deadline, it will be documented in the appeal file.

Members are notified of the appeals process (both internal review and independent external review) in the Evidence of Coverage (EOC). All members receive information on how to obtain a copy of the EOC on an annual basis. The EOC is located on the VCHCP website and members can obtain a hard copy, upon request, by contacting Member Services. This information includes the Plan's local and tollfree number, access to telephone relay systems, notification of linguistic services and cultural assistance. Also included is the DMHC's appeals process, the Independent Medical Review System and the DMHC's toll-free number and website address. Information regarding the right to independent external review includes the state's Department of Managed Health Care's (DMHC) toll-free telephone and TDD numbers as well as the department's Internet web site address.

Members may register appeals with VCHCP by mail, email, fax, online, in person or by calling:

Ventura County Health Care Plan
2220 E. Gonzales Rd. Ste. 210-B
Oxnard, CA 93036
**Phone: (805) 981-5050 or (800) 600-VCHP**
**Fax: (805) 981-5051**
**Email:** vchcp.memberservices@ventura.org
**Online via website:** www.vchealthcareplan.org

**For Language Assistance services, call VCHCP at (805) 981-5050. For TDD/TTY for the hearing impaired, call (800) 735-2929 to communicate in English or (800) 855-3000 to communicate in Spanish.**

Members with limited English proficiency who call the Plan are provided with information regarding the appeal process and given assistance during the appeal process through a bilingual staff member or through a language assistance line.

A member has a right to representation at any time during the appeal process. The right of the member to be represented by an attorney or any other representative, for any UM decision including an internal or external appeal, is clearly stated in the denial notification letter. This appointment must be in writing. Members can obtain an Authorized Representative form to submit by calling Member Services or visiting VCHCP in person.

The following persons may be submitted and considered as an authorized representative:

- A friend, relative or legal representative
- A parent of a child under 18, except that the child must appoint the parent as authorized representative if the child has the legal right to control release of relevant information.
- A court- appointed guardian, except the ward must appoint the court-appointed guardian as authorized representative if the ward has the legal right to control release of relevant information.
- A court-appointed conservator
- An agent under a currently effective health care proxy, to the extent provided under state law.

The Plan allows for submission of appeals up to 180 calendar days following an adverse determination. This information is included in the denial determination letter sent to the member and provider.

Upon receipt of an appeal, the Member's reason for appealing the previous decisionis logged into the medical management / documentation system known as QNXT and assigned a category code under call tracking. The date of the appeal is the date in which it was received by the Plan, whether or not all necessary information is available at that time. If a non-urgent appeal is received by fax outside of normal business hours, the date of receipt is when it arrives at the organization even if outside of normal business hours. VCHCP notifies both members and practitioners of the procedure for receiving and dating appeals that are received outside of normal business hours. This procedure does not apply to urgent or expedited appeals which are described below. Appeals for decisions other than medical necessity or benefit coverage are handled by Member Services. See the Grievance and Appeals Program Description for details. Appeals for medical necessity and benefit coverage denial determinations are handled by the UM department and are forwarded from Member Services to a qualified health professional in UM.

A written acknowledgement letter is sent to the member within 5 calendar days noting that the appeal has been received, the date of receipt, and the name of the plan representative and telephone number and address of the plan representative who may be contacted about the appeal.

Documentation is continued in the QNXT system to include all submitted information from the member and/or physician, investigation of all aspects of clinical care, the substance of the appeal and any actions taken and review of appropriate criteria until the file is completed. Actions that are documented may include, but are not limited to, all previous denial or appeal history and any follow-up actions related to the denial and conducted before the current appeal. VCHCP fully investigates the contents of the appeal, and all findings are documented. A full investigation may also include contacting other departments within the Plan or practitioners or organizational providers that have been involved in the member's clinical care.

The appeal request and all documentation regarding the appeal is forwarded to a physician reviewer in a same or similar specialty with similar credentialing's and licensure as those that typically treats the medical condition or health problem, or a physician who has experience treating the same problems as those in question and similar complications of those problems, performs the procedure or provides the treatment as the field of medicine involved in the case, one not involved in the original decision and not a subordinate of that individual. An exception to this would

be the initial reviewer conducting a re-review and overturning their original decision. The case is reviewed in its entirety without deference to the initial denial decision.

If an appropriate same or similar specialist is not available at the Plan, the case is contracted out to an independent review organization (IRO) for appeal determination.

A new determination and notification to the member is made regarding the reversal or maintenance of the modification or denial status within 30 calendar days of receipt of the preservice appeal. For postservice appeals, a decision and notification to the member is made within 30 working days of obtaining all necessary medical information, not longer than 60 calendar days from receipt of the appeal. The only exception to this time frame would be if the member voluntarily agrees to extend the appeal time frame.

The appeal determination letter includes the specific reason(s) for the decision, in easy-to-understand language; reference to the benefit provision, clinical guideline or protocol, specific criterion upon which the decision was based; application of this information specific to the member; notification of the ability for obtaining the benefit provision, clinical guideline or protocol, as well as any documentation available relevant to the appeal, free of charge, upon request. VCHCP uses plain language that a layperson would understand and does not use abbreviations, acronyms, or health care procedures codes that are not clearly explained in the letter. The letter also includes the title of each reviewer for a benefit appeal or, for the medical necessity review, the title, qualifications/credentials and specialty of the clinical reviewer(s) and the title for each nonclinical reviewer and a statement of participation in the appeal process. The names of these individuals will be provided upon request.

VCHCP appeals process includes one internal appeal level. Further appeal rights are included in the notification letter, including information regarding the process to appeal to the DMHC for an Independent Medical Review as follows:

"The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (**1-805-981-5050**) or (**1-800-600-8247**) and for hearing impaired members: TDD to Voice (**1-800-735-2929**); Voice to TDD (**1-800-735-2922**) for English or (**1-800-855-3000**) for Spanish and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit

any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-466-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online."

Note: this is the same information found in the member's EOC.

In rare instances, the Plan may refer an appeal directly to an independent review organization without conducting an internal review. However, this is only possible with the member's permission.

For appeals that are overturned, the determination letter includes the decision and the date.

For any modifications of the original decision, all necessary adjustments are made including reversals of decision to modify or deny requests for services processed within VCHCP's approved time frame and financial adjustments made in the next regularly scheduled VCHCP check processing.

Determinations on behavioral health treatment appeals are delegated to the Plan's PBH, OptumHealth Behavioral Solutions of California. Such delegation accepts that a licensed psychiatrist renders all denial and appeal decisions related to medical necessity determinations or a licensed psychologist can render such decisions for outpatient services rendered by non-physicians practitioners.

Determination letters can be sent translated into Spanish when appropriate to meet member's linguistic needs. VCHCP also prepares appeal notices based on the members' cultural needs upon request.

**Expedited Appeals**

An expedited appeal is reserved for denials of an urgent nature, when a delay in a decision might seriously jeopardize the life or health of a member. Expedited appeals may include procedures, medications, admissions, continued stay or other health care services for a member who has received emergency services, but has not been discharged from a facility. Expedited review is granted for all requests concerning admissions, continued stay or other health care services for a member who has received emergency services but has not been discharged from a facility.

An expedited appeal is therefore not appropriate for postservice appeals.

Expedited appeals are submitted by phone or in writing, through member services. A member, the member's representative or a practitioner acting on behalf of the member may request an expedited appeal. The intake, investigation and documentation processes are the same as with those described above for Preservice and Postservice appeals, however, the time frame for a decision is accelerated. Members and practitioners are notified orally or in writing of the decision in a timely manner appropriate to the severity and urgency of the condition but not longer than 72 hours, inclusive of weekends and holidays, after the appeal is received. The 72-hour timeframe begins immediately upon receipt of the request. The Plan provides for an Administrator on call, 24 hours a day/7 days a week, to respond to such requests. The practitioner is sent a confirmation of the decision within 24 hours of the decision not to exceed 72 hours of the receipt of appeal, via phone call or fax notification. The member is then sent a confirmation of the decision in writing within two (2) working days of making the decision. The written notification provides the same information as described above for Preservice and Postservice appeals.

**Continued Coverage**

Applies to appeals of denials, reduction, or termination of coverage for an ongoing course of treatment for which coverage was previously approved. It does not apply to requests for extension of course of treatment beyond that already approved. It is VCHCP's policy to allow members to have continued coverage pending the outcome of an internal appeal of a concurrent care decision until the end of the approved treatment period, or determination of the appeal, subject to regulatory and contractual obligations.

**Interface to the Plan's Quality Assurance Process**

In order to evaluate opportunities for administrative practice improvements, referral process improvements, and educational opportunities for members and physicians, VCHCP collects and analyses member satisfaction information, including, but not limited to, modification and denial data, appeals data including overturns and upholds, summary of processes and summary of disposition and outcomes. VCHCP reports the results of these evaluations to the Member/Provider Experience Committee (MPEC) and Standing Committee, which may make recommendations for change based on these results.

**Biomarker Testing (SB496)**

Under Section 1367.667(d) of SB496, restricted or denied use of biomarker testing for the purpose of diagnosis, treatment, or ongoing monitoring of any medical condition is subject to grievance and appeal processes under state and federal law.

**A. Review & Revision History:**

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| Revision Date | Content Revised (Yes/No) | Contributors | Review/Revision Notes |
|---|---|---|---|
| 2/9/17 | Yes | Catherine Sanders, MD; Robert Sterling, MD, Faustine Dela Cruz, RN | Annual review; updated to reflect summary of processes and summary of disposition and outcomes of appeal data evaluations are reported to the Member/Provider Experience Committee (MPEC) instead of Quality Assurance. |
| 11/29/17 | Yes | Catherine Sanders, MD; Robert Sterling, MD, Faustine Dela Cruz, RN | Changed “prudent layperson” to “reasonable person” language as required by DMHC.<br>Updated Member Services contact information. |
| 2/14/19 | No | Catherine Sanders, MD; Robert Sterling, MD, Faustine Dela Cruz, RN | Annual review; minor formatting update only. |
| 2/13/20 | Yes | Howard Taekman, MD; Robert Sterling, MD, Faustine Dela Cruz, RN | Annual review; updated the dmhc toll free telephone number to 1-888-466-2219 and internet website to http://www.dmhc.ca.gov |
| 2/11/21 | Yes | Howard Taekman, MD; Robert Sterling, MD, Faustine Dela Cruz, RN | Annual Review |
| 2/17/22 | Yes | Howard Taekman, MD; Robert Sterling, MD, Faustine Dela Cruz, RN | Annual Review; added the email option for submitting an appeal; updated the DMHC required language so that website is all one word. |

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| 8/11/22 | Yes | Faustine Dela Cruz, RN, Meriza Ducay, RN<br>Howard Taekman, MD, Robert Sterling, MD | Updated with DMHC's language regarding Emergency services where a person reasonably believed that an emergency medical condition existed. |
| 2/2/23 | No | Howard Taekman, MD; Robert Sterling, MD, Faustine Dela Cruz, RN | Annual Review |
| 2/8/24 | Yes | Howard Taekman, MD; Robert Sterling, MD, Faustine Dela Cruz, RN, Meriza Ducay, RN | Updated with NCQA standards for Utilization Management Element 8A. |
| 6/18/2024 | Yes | Howard Taekman, MD; Robert Sterling, MD, Faustine Dela Cruz, RN | Updated to address Section 1367.337(d) per DMHC's requirement. |
| 2/20/25 | Yes | Howard Taekman, MD; Robert Sterling, MD, Faustine Dela Cruz, RN | Updated the DMHC language on appeal to the DMHC for an Independent Medical Review |