Anthem Provider Appeal
Policy and Procedure

I. INTRODUCTION

Anthem Health Plans of Virginia, Inc., d/b/a Anthem Blue Cross and Blue Shield, HealthKeepers, Inc., Peninsula Health Care, Inc., and Priority Health Care, Inc., (hereafter collectively referred to as “Anthem”), are committed to establishing and maintaining an internal appeal and external review process for physicians with respect to Adverse Determinations to the extent Anthem both makes the Adverse Determination and administers the member appeals and/or external review processes.

These policies and procedures address how Anthem identifies and manages physician appeals, including pre-service, post service, expedited and external appeals. Physician requests for a review of Anthem decisions on claim errors, claim corrections, and claims denied for additional information are not subject to review or appeal under these policies and procedures. No physician will be penalized for filing an appeal.

II. DEFINITIONS

A. “Adverse Determination” means any determination made by Anthem that certain services are not covered services because they are not Medically Necessary or are experimental or investigational in nature where Anthem both makes the Adverse Determination and administers the member appeals and external review processes.

B. “External Appeal” means a request for an independent, external review of the final Adverse Determination made by Anthem through its internal appeal process.

C. “External Review” shall have the meaning given to it in section III.C.1, below.

D. “Independent Review Organization” shall have the meaning given to it in section III.C.1, below.
E. **“Medically Necessary” or “Medical Necessity”** mean health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease; and (c) not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease. For these purposes, “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

F. **"Physician Advisor"** means a physician licensed to practice medicine in the Commonwealth of Virginia or under a comparable licensing law of a state of the United States who provides medical advice or information to Anthem in connection with its utilization review activities.

G. **“Physician Specialty Society”** means United States medical specialty society that represents diplomats certified by a board recognized by the American Board of Medical Specialties.

H. **“Pre-Service Appeal”** means a verbal or written request to change an Adverse Determination made by Anthem for care or service that has not yet been provided to the member.

I. **“Post-Service Appeal”** means a verbal or written request to change an Adverse Determination made by Anthem for care or service already rendered.

J. **“Qualified Reviewer”** means a physician in the “same specialty” as the physician who treated the condition. “Same specialty” shall mean a physician with similar credentials and licensure as those who typically treat the condition or health problem in question in the appeal or a physician who has experience treating the same problems as those in question in the appeal, in addition to experience treating similar complications of those problems.
III. POLICIES

A. Experimental/Investigational Denials
In applying experimental and investigational exclusions to either proposed health care services or as part of a Post-Service Appeal to Anthem, Anthem shall consider credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, the views of physicians practicing in relevant clinical areas, the individual clinical circumstances of the particular member, the views of the treating physician and any other relevant factors.

B. Reconsideration and Internal Appeals of Adverse Determinations For Physicians

1. Pre-Service Appeals
   a) Physicians shall have the right to file a Pre-Service Appeal, if they are appealing on the member’s behalf. Authorization must be obtained from the member in writing.
   b) For urgent Pre-Service Appeals, the physician shall be automatically deemed the authorized representative of the member.
   c) Pre-Service Appeals filed by physicians on behalf of a member will be handled by Anthem under the appeal process available to the member based on the terms of the member’s health benefit plan and the applicable state and federal laws and regulations (See Anthem Member Appeal Policy and Procedure).

2. Reconsiderations and Post-Service Appeals
   a) Prior to requesting a reconsideration or an internal Post-Service Appeal, physician shall use best efforts to first seek written authorization to proceed as the member’s representative. If physician obtains the member’s consent to proceed on their behalf, then physician’s reconsideration and appeal rights are those of the member and physician is bound by the decision rendered in the member’s appeal process (See Anthem Member Appeal Policy and Procedure). If physician cannot obtain the member’s consent to proceed on
their behalf, then physician’s reconsideration and appeal rights are as set forth in b) – e), below.

b) Subject to the provision above, physicians shall have the right to a reconsideration of an Adverse Determination. Any such reconsideration shall be subject to the following rules/requirements:

- Reconsiderations must be requested by physicians within 15 months from the date of the service in question or 6 months from the date of Anthem’s Adverse Determination, whichever is longer.
- Reconsiderations may either be initiated via telephone or facsimile request from a physician.
- Reconsiderations shall be performed by a Qualified Reviewer or Physician Advisor, other than the physician that made the initial Adverse Determination.
- Anthem shall render a written decision to the treating physician and member within 10 working days of the request for reconsideration. If the decision on reconsideration is adverse, the decision will include the criteria used and the clinical reason for the adverse decision. Further, the written notice of any adverse decision on reconsideration will include a description of the process by which the physician may request the appeal described in c), below.

c) Subject to the provisions above, if the reconsideration results in the Adverse Determination being upheld, Anthem has a one level internal appeal process for physicians in which a Qualified Reviewer, other than the physician that made the initial Adverse Determination, reviews and may deny the appeal of the physician who treated the condition. This right of appeal is subject to the restrictions set forth in D, below.

- A nurse or other health care professional employed by Anthem may review the internal appeal and may grant but not deny the appeal. If the nurse or other healthcare professional does not grant the appeal, then a Qualified Reviewer, designated by Anthem, other than the one that made the initial Adverse Determination, shall review and decide the internal appeal in accordance with applicable Anthem health care clinical guidelines.
d) If the Post-Service appeal decision is favorable to a non-participating physician, then payment by Anthem will be subject to the terms, conditions and limitations of the applicable health benefit plan, however, payment will be issued directly to the non-participating physician.

e) All internal Post-Service Appeals filed by physicians shall be adjudicated within the time limits established under regulations issued by the Department of Labor regardless of whether ERISA applies.

3. Expedited Reconsideration and Appeal

a) When an Adverse Determination or adverse reconsideration determination is made and the treating physician believes that the decision warrants an immediate appeal, the physician shall have the opportunity to appeal the Adverse Determination or adverse reconsideration by telephone on an expedited basis. Further, the treating physician shall have the opportunity to appeal immediately, by telephone, on an expedited basis, an Adverse Determination or adverse reconsideration relating to a prescription to alleviate cancer pain.

b) The decision on an expedited appeal shall be made by a Qualified Reviewer.

c) Anthem shall make its decision on the expedited appeal no later than one business day after it receives all necessary information.

d) An expedited appeal may be requested by physicians only when the regular reconsideration and appeals process would delay the rendering of health care in a manner that would be detrimental to the health of the patient or would subject a cancer patient to pain. The physician and Anthem shall attempt to share the maximum information by telephone, facsimile machine, or otherwise to resolve the expedited appeal in a satisfactory manner.

e) An expedited appeal decision upholding an adverse reconsideration decision may be further appealed through the standard internal appeal process (under III.B.2.c).
C. External Review Process for Physicians

1. If the Anthem upholds its initial Adverse Determination during the processes described in III.B, above, and the cost of the service at issue exceeds the threshold amount, if any, the member must satisfy in order to seek external review under the terms of the applicable health benefit plan, Anthem shall make available to physician the option to seek external review of the Adverse Determination through an independent review organization (“Independent Review Organization”) identified by Anthem (“External Review”). This right of appeal is subject to the restrictions set forth in D, below.

2. The physician shall have the option to submit a written request for External Review within sixty (60) days from the date of the internal Post-Service Appeal denial decision by Anthem. Election to pursue External Review is at the option of the physician, who may instead choose any other remedy available as a matter of law or contract.

3. External Review is not available for a physician before the physician has exhausted the internal Post-Service Appeal process unless both the Anthem and the physician agree to forego the internal Post-Service Appeal and proceed directly to External Review or Anthem cannot provide a Qualified Reviewer for internal appeal.

4. Physicians seeking External Review shall pay a filing fee of $50; provided that if the matter involves services or supplies for which Anthem requires pre-certification then the filing fee shall be the lesser of (i) $250 and (ii) the sum of $50 and the amount by which the amount in dispute exceeds $1,000, towards the cost of the External Review for each External Review requested. Payment must be submitted along with the External Review request; provided, however, that physician shall be entitled to a refund of such payment in the event that the physician prevails in the External Review process.

5. Any decision issued pursuant to an External Review process, regardless of whether such External Review process is initiated and pursued by a member or a physician, shall be binding upon both the physician and the Anthem.
6. Anthem will contract with the Independent Review Organization to conduct a de novo review of the case. For coverage issues other than a determination of Medical Necessity, the member’s health benefit Plan Documents will control.

7. In the event an External Review process is initiated, Anthem shall promptly, but in any event no later than ten (10) business days following receipt of the request, submit documentation pertaining to the appeal to an Independent Review Organization. Anthem shall require that the Independent Review Organization provide a decision within thirty (30) days of Anthem’s submission of all necessary information. The external reviewer designated to conduct the review by the Independent Review Organization shall be of the same specialty (but not necessarily the same sub-specialty) as the appealing physician.

8. The Independent Review Organization’s compensation shall not be tied to the outcome of the reviews performed. Likewise, the selection process among qualified Independent Review Organizations will not create any incentives for Independent Review Organizations to make decisions in a biased manner.

9. In the case of a state-required external review process that is available to physicians without the member’s consent and that is different than the process herein set forth, only the state-required program shall be utilized where applicable.

10. If the external review decision is favorable to a non-participating physician, then payment by Anthem will be subject to the terms, conditions and limitations of the applicable health benefit plan, however, payment will be issued directly to the non-participating physician.

D. Restrictions on Physicians Right to Initiate Internal Post-Service Appeals and External Review

Notwithstanding the preceding provisions of this policy and in addition to any requirements contained above, physicians may not initiate an internal Post-Service Appeal or External Review of any denied service if:

1. The member (or his or her representative) or the physician (either independently where Anthem is required to accept an independent physician appeal by state law or as the member’s representative) filed a Pre-Service Appeal pertaining to the same denied service; or
2. The member (or his or her representative) is currently seeking or has sought review related to the same denied service. In the event both member (or his or her representative) and physician seek review of the same denied service, the member’s review shall go forward and the physician’s request for review will be dismissed; or

3. As to External Review only, the member is covered under a self-insured plan and the Plan sponsor has not agreed by contract to participate in Anthem’s External Review program set forth in this policy; or

4. The member (or his or her representative) has filed suit under §502(a) of ERISA or other suit for the denial of health care services or supplies regarding an Adverse Determination. In that event, or if such a suit is subsequently initiated, the member’s lawsuit shall go forward and the physician’s claims shall be dismissed and may not be brought by or on behalf of the physician in any forum; provided that such dismissal shall be without prejudice to any physician seeking to establish that the rights sought to be vindicated in such lawsuit belong to such physician and not to such member.

5. Nothing contained in this policy is intended, or shall be construed, to supersede, alter or limit the rights or remedies otherwise available to any Person under §502(a) of ERISA or to supersede in any respect the claims procedures under

6. §503 of ERISA.

IV. PRECEDENTIAL EFFECT

The determination made with respect to any Adverse Determination pursuant to any internal appeal and External Review process referenced in this policy shall not act as precedent as to any other Medical Necessity or experimental or investigational determination under this policy.