

This section contains information about the processes for the following types of provider appeals and disputes:

- Dental Provider Appeals and Disputes
- Medical Provider Appeals and Disputes
- Hospital/Facility Appeals and Disputes

Member appeal information is available in the Appeals for Members section of this manual.

Medicare Advantage Member appeal information is included in the Medicare Advantage plans section of this manual.

### Glossary of terms

**Adverse Determination (Appeal):** For purpose of the provider appeal process means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of any of the following:

- Application of utilization review;
- Determination that a treatment is not Medically Necessary; or
- Denials related to upcoding (including DRG);
- Application of a Current Procedural Terminology (CPT®) modifier, and/or other reassignment of a code by us to patient specific factual situations, including the appropriate payment when two or more CPT Codes are billed together, or
- Whether a payment enhancing modifier is appropriate.

**Dispute:** For purpose of the provider dispute process means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of any of the following:

- Failure to secure Preauthorization
- Failure to notify of Inpatient Admission
- Determination that services are related to a Hospital Acquired Condition
- Determination that records do not support billing during a Hospital Bill Review (Line Item Review)
- Any other dispute that does not meet the definition of Adverse Determination outlined in the Glossary

**Appeal Record:** Includes all information which was relied upon in making the payment determination; or was submitted, considered, or generated in the course of making the payment determination, whether or not such document, record, or other information was relied upon in making the payment determination; or demonstrates compliance with our claims procedures, administrative processes and safeguards; or constitutes a statement of policy or guidance with respect to the payment determination.

In this administrative manual, "Regence" refers to the following: Regence BlueShield of Idaho, Regence BlueCross BlueShield of Oregon, Regence BlueCross BlueShield of Utah, and Regence BlueShield (in select counties of Washington). When information does not apply to all these plans across the four states, then this administrative manual will identify the plan(s) or state(s) to which that specific information applies.

**Claims:** A provider's request for payment submitted in the usual course of business between that provider and us.

**External Review:** Review of an Adverse Determination Appeal submitted to the External Review Organization with which we have contracted to provide these review services by a provider in compliance with the terms of the Adverse Determination Appeal Process.

**External Review Organization ("ERO"):** An independent organization employing providers and other medically qualified individuals or experts, which acts as the decision maker for External Reviews, through an independent contractor relationship with us.

**Provider:** Provider means practitioner, clinic, hospital, or other health care professional as defined in the Agreement.

**Provider Appeal:** Formal request from a contracted provider to reconsider an Adverse Determination when the provider is at financial risk for the services.

**"Our" or "We":** References to our or we mean Regence or the Company.

**"You" or "Your":** References to you or your mean Practitioner as defined in the Agreement.

### **Medical, Dental, and Hospital Provider Adverse Determination Appeal and Dispute Process:**

#### **Introduction**

##### **A. Applicability**

Our Provider Adverse Determination Appeal and Dispute process will apply when the provider is at financial risk for the cost of the claim. The member appeal process will apply when the member is or may be at financial risk for the cost of the claim.

The following are not eligible under the Adverse Determination Appeal or Dispute process:

- (a) Appeals made by non-contracted providers. Appeals by non-contracted providers may be eligible for the member appeal process.
- (b) The member has filed suit under Section 502 of ERISA or other suit for denial of the health care services or supplies regarding an Adverse Determination.

##### **B. Process for Submission of all levels of Adverse Determination Provider Appeals or Disputes**

1. Use the *Provider Appeal Form*, which can be found on our provider website at **regence.com**.
2. The completed appeal form or a written description of the issue(s) on the appeal must be submitted to us by facsimile to **1 (866) 273-1820**.

Very large documents or documents sent by certified mail may be sent to:

Regence  
Attention: Provider Appeals  
P.O. Box 1248  
Lewiston, ID 83501-1248

*Note:* Federal Employee Program (FEP) appeals are not accepted by fax. They must be mailed to:

Regence - FEP  
P.O. Box 1388  
Lewiston, ID 83501-9998

3. The following information must be submitted with the *Provider Appeal Form* or the written description of the issue(s) on appeal:
  - (a) A detailed description of the disputed issue(s);
  - (b) The basis for disagreement with the decision; and
  - (c) All evidence and documentation supporting your position.

### **Provider First Level (Internal) Appeals and Disputes**

#### **A. Time Period for Submission of a Level One Adverse Determination Appeal or Dispute by Provider**

1. **Regence BlueShield of Idaho** providers not located in Asotin or Garfield counties in Washington: Within 12 months after payment of the claim or notice that the claim was denied. Regence BlueShield of Idaho providers located in Asotin or Garfield counties in Washington: Within 24 months after payment of the claim or notice that the claim was denied or within 30 months for claims subject to coordination of benefits.

**Regence BlueCross BlueShield of Oregon** providers not located in Clark County, Washington: Within 18 months after payment of the claim or notice that the claim was denied or 30 months for claims subject to coordination of benefits. Regence BlueCross BlueShield of Oregon providers located in Clark County, Washington: Within 24 months after payment of the claim or notice that the claim was denied or within 30 months for claims subject to coordination of benefits.

**Regence BlueCross BlueShield of Utah** providers: Within 12 months after payment of the claim or notice that the claim was denied, 24 months for claims subject to coordination of benefits, or 36 months for claims involving a recovery from a state or federal health care program.

**Regence BlueShield (select counties in Washington)** providers: Within 24 months after payment of the claim or notice that the claim was denied or 30 months for claims subject to coordination of benefits.

2. If a provider wishes to appeal a refund request initiated by us, he or she can submit an Appeal within the same timeframe listed above. Note: The timeframe begins when the written request for refund is sent to the provider.

Failure to request review with all applicable documentation within the stated time period will preclude the right to appeal and may jeopardize the right to contest the decision in any forum.

#### **B. Level One Internal Appeal and Dispute Review Provisions**

1. The individual reviewing the issue(s) of the appeal/dispute will meet the following criteria:
  - (a) Is not an individual who made or consulted in the initial determination,
  - (b) Is not a subordinate of an individual involved in the initial determination.

2. If your appeal/dispute determination is unfavorable in whole or in part, we will communicate a written decision on an Internal Review of an Adverse Determination Appeal within thirty (30) calendar days of our receipt of all documentation reasonably needed to make the determination. A description of the External Review option will be supplied with the written decision, including the time limit for requesting External Review.
3. Additionally, for unfavorable determinations in whole or in part, you have the option to seek a Level Two appeal/dispute. A description of the Level Two Review option will be supplied, including the time limit for requesting a Level Two Review which is ninety (90) calendar days after the written Internal Review determination.

**C. Qualified Reviewer**

For an Internal Review of decisions involving Utilization Review or whether a treatment is Medically Necessary only a medical or dental provider holding an active, unrestricted license, who possesses the appropriate level of training and/or expertise required to evaluate the necessity of the service under review, and who is other than the one that made the initial Adverse Determination, may deny the appeal of the provider who treated the condition. A nurse or other health care professional employed by us may review the Adverse Determination Appeal and may grant but not deny it. If the nurse or other health care professional does not grant the appeal, then a Qualified Reviewer, designated by us, other than the one that made the initial Adverse Determination, shall review and decide the Adverse Determination Appeal in accordance with our medical and reimbursement guidelines.

**Provider Second Level Review Process**

A second level review is available for Adverse Determination Appeals and Disputes.

**Level Two Adverse Determination Appeals (Binding External Review):**

If the initial determination is upheld through the Internal Review process, the option to seek External Review of the determination will be made available for Adverse Determination Appeals.

Exception: Certain Facilities with unique provider agreements that do not specify an External Review option will be provided with the option for the Level 2 Internal Dispute process.

**A. Prerequisites for Level Two Adverse Determination Appeals (Binding External Review):**

1. The Level One Internal Review process must be exhausted before requesting a Level Two External Review of the determination unless both we and the provider agree in writing to forego the Internal Review process and proceed directly to External Review.
2. A provider who chooses External Review will submit a written notice to us within ninety (90) calendar days from the date of the Internal Review Determination.
3. The appeal meets the definition of Adverse Determination as described in the Glossary of Terms listed above.
4. Only one Level two review is available. If provider utilizes a second level internal review process (for Facilities), a second level external review will not be made available.

**B. Level Two Adverse Determination Appeals (Binding External Review) Provisions:**

1. An Adverse Determination Appeal may be submitted for External Review. If the amount in dispute is less than \$500, you have the option to request a cumulative appeal by notifying us that you intend to submit additional Adverse Determination Appeals for External Review on the same or similar issues during the one-year period following the submission of the original Adverse Determination Appeal and the cumulative amount in dispute over the one-year period exceeds \$500. The request for External Review is at the option of the provider, who may instead choose any other dispute resolution allowed by the Agreement. If chosen, the External Review shall be binding.
2. The Adverse Determination Appeal must be submitted to us in writing. The Administrative Manual and the Provider *Appeal Form* provide detailed contact information. We will forward Adverse Determination Appeals that meet the prerequisites as listed in section A above to a designated External Review Organization.
3. The provider shall pay a filing fee of \$50.00 for each Adverse Determination Appeal.
  - (a) We shall notify you that the filing fee is due.
  - (b) Payment must be submitted before the External Review begins; provided, however, that you shall be entitled to a refund of such payment in the event that you prevail in the External Review process.
  - (c) You shall submit the filing fee within sixty (60) calendar days of notice from us that filing fee is due or the External Review request will be closed.
4. Upon receipt of a timely filing fee, we will provide to the External Review Organization the Appeal Record.
5. The External Review Organization will process the Adverse Determination Appeal and notify you and us of its recommendation within thirty (30) calendar days of receipt of the filing fee. The decision will be binding on us and you.
6. In the event that the External Review decision requires payment by us, such payment shall be initiated within fifteen (15) calendar days after we receive notice of the determination.

**Level Two Disputes (Non-Binding Internal Review):**

If the initial determination is upheld through the Internal Review process, the option to seek a second level Internal Review of the determination will be made available for Disputes and/or for Adverse Determination appeals for certain facilities with unique provider agreements that do not specify an External Review option.

**A. Prerequisites for Level Two Disputes (Non-Binding Internal) Review:**

1. The Level One Internal Review process must be exhausted before requesting a Level Two Internal Review.
2. Provider must submit a written notice to us within ninety (90) calendar days from the date of the Level One Internal Review Determination Letter.
3. The appeal meets the definition of Dispute as described in the Glossary of Terms listed above. These disputes include:
  - Failure to secure Preauthorization
  - Failure to notify of Inpatient Admission
  - Determination that services are related to a Hospital Acquired Condition
  - Determination that records do not support billing during a Line Item Audit
4. Any other dispute that does not meet the definition of Adverse Determination outlined in the Glossary of Terms listed above.
5. Only one Level Two review is available. If provider utilizes a second external level review process outlined above, a second internal review will not be made available.

**B. Level Two Dispute (Non-Binding Internal) Review Provisions:**

1. The individual reviewing the issue(s) on appeal will meet the following criteria:
  - (a) Is not an individual who made or consulted in the initial determination.
  - (b) Is not a subordinate of an individual involved in the initial determination.
2. If your appeal determination is unfavorable in whole or in part, we will communicate a written decision on a Second Level Internal Review of the Dispute within thirty (30) calendar days of our receipt of all documentation reasonably needed to make the determination. This is the final level of dispute.

The provider has the option to request an in-person meeting. If no request for an in-person meeting is made, the process for review outlined above will proceed without one. If an in-person meeting is requested, the meeting will be held within 45 days of the written request. If your appeal determination is unfavorable in whole or in part, we will communicate a written decision on a Second Level Internal Review of the Dispute within thirty (30) calendar days of the in-person meeting. This is the final level of dispute.

**External Audit and Investigation Appeal Process**

The External Audit and Investigation Appeal Process is intended to give you an opportunity to request reconsideration of audit findings issued by our External Audit and Investigation Department and to ensure we have reviewed all information relevant to the audit findings. Please note that contract terminations resulting from audit findings must follow the Provider Contract Termination Appeal Process.

**A. Reconsideration Request**

Upon receipt of our audit findings, you have **forty-five (45) business days** to review and dispute these findings before the audit becomes final. In order to appeal the findings, you must submit a written request for a reconsideration of audit findings. You will be given the address for where to send your reconsideration request with your audit findings.

The request must be received by us within **forty-five (45) business days** of your receipt of the audit findings and must include, at a minimum, the following:

- A detailed statement of the issue(s) in dispute
- At the election of the provider, notification of a request for a meeting with the panel reviewing the issue(s) in dispute
- Any documents which the provider contends supports his/her position  
(Exception: Please note that all documentation required to justify your billing, including but not limited to chart notes, must be present in your files at the time of an audit. Additions to file documentation and/or the production of files that were not made available to us at the time of an audit will not be considered in connection with an appeal involving adverse audit findings. We will, however, consider your explanation as to why the documentation was not present at the time of the audit.)

If we do not receive such a reconsideration request within forty-five (45) business days of your receipt of the audit findings, the findings will be final.

The request for reconsideration will be reviewed by the manager of our External Audit and Investigation Department, investigators within that department, and our other representatives, as determined by the manager of the department (hereinafter referred to as the "Panel"). At the discretion of the Panel, one of our Medical Directors may be consulted prior to the final decision.

A meeting, prior to the Panel's review of your request for reconsideration, can be arranged either at your office or at our office, as mutually convenient. You must request this meeting when submitting your request for reconsideration.

At the meeting, you may appear in person and may be accompanied by an attorney or other representative. You and your representative may make an oral statement to the Panel and respond to questions from the Panel. The purpose of this meeting is to give you an opportunity to present your position to the Panel in person.

If the Panel needs additional documentation to reach a decision, the additional documentation must be submitted within **twenty (20) calendar days** of the date of the Panel's written request for information, unless your written request for a reasonable extension of time is granted.

- If the requested documentation is received on time, it will be included in the request for reconsideration.
- If the documentation is not received on time, the request for reconsideration will continue and a decision will be made based on the information originally submitted. You will be sent written notice of the decision within **forty-five (45) business days** following the meeting with the Panel or, if no such meeting was requested, within **forty-five (45) business days** of our receipt of the audit reconsideration request, not including the time waiting for additional information from you. During the period of time in which we are waiting for additional information, the appeal decision time frame is suspended until the information is received or the time to respond to the request has expired.

**The decision on an audit reconsideration request is deemed final forty-five (45) business days after your receipt of the Panel's decision, unless a timely written request for a Medical Director Review is received.**

#### **B. Medical Director Review**

If you are not satisfied with the decision made following the reconsideration request to the Panel, you may request a Medical Director Review of the audit findings. The written request for a Medical Director Review and any supporting information must be received by us within **forty-five (45) business days** of your receipt of the Panel's decision. The address where to send your request will be included in our response to your request for reconsideration.

The Medical Director Review will be held no more than forty-five (45) business days following receipt of the request, not including the time in which we are waiting for additional information from you. The review will be conducted by a Medical Director who was not involved in an earlier review of the audit findings.

If the Medical Director needs additional documentation to reach a decision, the additional documentation must be submitted within **twenty (20) calendar days** of the date of the Medical Director's written request for information, unless your written request for a reasonable extension of time is granted.

- If the requested documentation is received on time, it will be included in the Medical Director Review.
- If the documentation is not received on time, the Medical Director Review will continue and a decision will be made based on the information originally submitted.

During the period of time in which we are waiting for additional information, the forty-five (45) business day clock to complete the Medical Director Review is suspended until the information is received or the time to respond to the request has expired.

You will be sent written notice of the decision within **forty-five (45) business days** following the Medical Director Review.

**The Medical Director Review is the final step in the External Audit and Investigation Appeal Process. Once a decision has been made by the Medical Director, the External Audit and Investigation Appeal Process has been completed and the decision shall be deemed final. If you are not satisfied with our decision after completing the External Audit and Investigation Appeal Process and want to continue to dispute the issue(s), you must initiate the appropriate process(es) as outlined in your Provider contract.**

### **Provider Contract Termination Appeals**

A contracted provider may initiate an appeal of a contract termination decision made by us through the Provider Contract Termination Appeal Process.

#### **1. Level One Appeal**

To request a Level One Appeal, you must send a written request to the Credentialing Department, at the address listed below within thirty (30) business days of receipt of the termination notification.

By facsimile: 1 (888) 335-3002

By mail:

Provider Contract Termination Appeal - Level One  
Attention: Credentialing Department  
P.O. Box 21267, M/S S-333  
Seattle, WA 98111-3267

A request for an appeal regarding a contract termination must include, at a minimum:

- A detailed description of the disputed issue(s)
- The basis for your disagreement with the decision
- All evidence and documentation supporting your position
- (Exception: Please note that all documentation required to justify your billing, including, but not limited to, chart notes, to be present in your files at the time of an audit. Additions to file documentation or the production of files that were not made available to us at the time of an audit will not be considered in connection with an appeal involving adverse audit findings. We will, however, consider your explanation as to why the documentation was not present at the time of the audit.)
- Your requested outcome

Upon receipt of the Level One Appeal request, we will send you an acknowledgement letter within **fifteen (15) business days**.

The Level One Appeal Panel is comprised of at least three (3) individuals that have not been directly involved in the Credentialing Committee or termination decision and have the appropriate level of knowledge and training to understand the issues presented. At least one panel member must be a participating provider.

Level One Appeals meetings are held on a bi-monthly basis. Your appeal will be scheduled for review at the next available Level One Appeal meeting, subject to the time your appeal request and any additional information are received and the volume of appeals being reviewed by the panel.

If additional information is requested, it must be submitted within fifteen (15) business days of the date of the written request for information, unless a written request for a reasonable extension of time is granted.



- If the information is not received on time, a decision will be made at the next Level One Appeal panel meeting, based on the limited information available.
- If the additional information is received on time, the new information will be taken into consideration at the next Level One Appeal panel meeting.

Information not submitted within the time limit will not be considered for the Level One Appeal, unless otherwise allowed by the Level One Appeal panel.

You will receive a written determination within ten (10) business days of the Level One Appeal panel decision.

**The Level One Appeal decision is deemed final on the thirtieth (30th) business day after you receive it, unless a written request for a Level Two Appeal is received timely.**

### **Level Two Appeal – “In-Person Hearing”**

If you are not satisfied with the results of the Level One Appeal, you may submit a written request to the Credentialing Department, at the address listed below, for a Level Two Appeal, “in-person hearing” **no later than thirty (30) business days** after your receipt of the Level One Appeal decision.

By facsimile: 1 (888) 335-3002

By mail:

Provider Contract Termination Appeal - Level Two  
 Attention: Credentialing Department  
 P.O. Box 21267, M/S S-333  
 Seattle, WA 98111-3267

The Level Two Appeal Panel is comprised of at least three (3) individuals that have not been directly involved in the Level One Appeal, the Credentialing Committee or the termination decision and have the appropriate level of knowledge and training to understand the issues presented. At least one panel member must be a participating provider.

The request for a Level Two Appeal must identify in detail the following:

- All issues on which you request re-evaluation
- Information not previously submitted to the Level One Appeal panel, if any
- (Exception: We expect all documentation required to justify your billing, including, but not limited to, chart notes, to be present in your files at the time of an audit. Additions to file documentation or the production of files that were not made available to us at the time of an audit will not be considered in connection with an appeal involving adverse audit findings. We will, however, consider your explanation as to why the documentation was not present at the time of the audit.)
- Your requested outcome

The hearing is generally completed within two (2) hours and will be scheduled for two (2) hours, unless you notify us when requesting your Level Two Appeal that additional time is needed. We will make our best efforts to accommodate reasonable requests for additional time, as long as we are notified when you request the Level Two Appeal.

Upon receipt of the Level Two Appeal request, we will send you an acknowledgement letter within **fifteen (15) business days**.

Level Two Appeals meetings are scheduled upon request. We will make our best efforts to provide proposed times and dates within sixty (60) business days of the Company's receipt of your Level Two Appeal request. Once you have been provided the proposed times and dates you will have **five (5) business days** to notify us of your preferred time and date for the Level Two Appeal hearing. If you fail to notify us of your preferred time and date for the Level Two Appeal hearing within five (5) business days of receiving the proposed times and dates, the hearing will be set on one of the proposed times and dates.

Prior to the Level Two Appeal hearing, you will receive a "**Notice of Hearing**". The "Notice of Hearing" will indicate the following:

- Date of the hearing
- Time of the hearing
- Location of the hearing
- Names of the members of the Level Two Appeal panel
- Reasons for the adverse action
- Names of witnesses who will testify on our behalf at the hearing
- Your rights at the hearing

At the hearing, you have the following rights:

- To have representation by an attorney or other person of your choice
- To have a court reporter make a record of the proceedings at an additional cost to you. Costs associated with the court reporter must be paid by you prior to receiving a copy of the transcript
- To call witnesses and to examine/cross-examine witnesses
- To present relevant evidence (as determined by the panel)
- To submit a written statement at the close of the hearing

Approximately **thirty (30) calendar days** before the scheduled date of the hearing, a Level Two Appeal binder will be sent to you or your representative. The binder will include, among other things, the documentation reviewed by the Credentialing Committee initially and at the Level One Appeal, as well as any documentation submitted by you. If you wish to submit additional information to further supplement the Level Two Appeal binder, this information, as well as a list of witnesses that you plan to call, examine, and cross examine at the hearing, must be received no later than **fourteen (14) calendar days** prior to the hearing date. Unless otherwise allowed by the Level Two Appeal panel, documentation and witnesses not submitted at least **fourteen (14) calendar days** prior to the hearing date will not be considered by the Level Two Appeal panel and should not be brought to the hearing for the panel's consideration. The only exception is that you may submit a written statement at the close of the hearing.

If the Level Two Appeal binder is later supplemented with new or revised information prior to the hearing, you will receive copies of the new or revised material as soon as practicable before the scheduled date of the hearing. After the Level Two Appeal binder has been finalized, it will be forwarded to the Level Two Appeal panel for review prior to the hearing. Neither you nor we may supplement the binder within **thirteen (13) calendar days** prior to the hearing, unless a written request for an exception is approved by the Chair of the Level Two Appeal panel.

You will receive written notification of the Level Two Appeal decision within **fifteen (15) business days** of the hearing. If the Level Two Appeal panel cannot reach a decision within **fifteen (15) business days**, or if additional information is needed to reach a decision, you will be informed of any additional information needed and a new date by which the decision will be made.

**Decisions of the Level Two Appeal panel related to contract terminations are deemed final. Once a decision has been made by the Level Two Appeal panel, you have completed the Provider Contract Termination Appeals process. If you are not satisfied with our decision after completing the Provider Contract Termination Appeal process and want to continue to dispute the issue(s), you must initiate the appropriate process(es) as outlined in your provider contract.**

**2. Additional Information Regarding the Provider Contract Termination Appeals Process**

**a. Provider Status During a Contract Termination Appeal**

You will continue as a participating provider; however, you will be temporarily removed from all provider directories and any pending action by us is put in abeyance until the appeal is resolved and a final decision is made. If, however, the basis for the termination decision relates to the health, safety or welfare of our members, or if the we have exercised our right to immediately terminate the provider contract for reasons allowed by the provider contract, your participation status will be terminated for the duration of the appeal process and reinstated only if you prevail during the Provider Contract Termination Appeal process.

**b. The Data Bank Reportable Actions**

We are required by law to report certain adverse actions or decisions against you to the Data Bank. If our termination decision stands, either by virtue of you choosing not to appeal or if the decision is upheld by the appeals panel, we may be obligated to report this termination to the Data Bank, as applicable. You may not “self-term” to avoid being reported to the Data Bank. Additional information on these reporting requirements is available on the Data Bank website, at [npdb.hrsa.gov](http://npdb.hrsa.gov).