PROVIDER APPEALS PROCEDURE

1. The Provider or his/her designee may request an appeal in writing within 365 days of the date of service
2. Detailed information and supporting written documentation should accompany the appeal
3. Providers may obtain assistance in filing an appeal by contacting Optima Health Provider Relations.
4. The appeal may be submitted by:
   - Facsimile: 866-472-3920
   - Mail: Optima Health
     Provider Appeals Department
     P.O. Box 62876
     Virginia Beach, VA 23466-2876
   - Delivery: Optima Health
     Provider Appeals Department
     4417 Corporation Lane, 3rd Floor
     Virginia Beach, VA 23462
5. The Provider Appeals Coordinator will thoroughly research and gather all relevant documentation including, but not limited to, claims processing history, scanned documents from the I-Max database, denial codes, medical records, operative notes, etc.
6. The following individuals may review each case: the Provider Appeals Coordinator, Appeals Manager or Team Coordinator, Medical Director, Network Management Contract Manager, and a Certified Professional Coder.
7. A decision will be rendered within 45 business days of receipt of the appeal request.
8. If the decision is made to reverse the payment decision, the Provider Appeals Coordinator will forward the information to the Claims Department for processing as appropriate (for specialty claim types) or reprocessed within the Appeals Department (Provider Appeals Coordinator-non specialty claim types only).
9. Written notification of the Plan's final decision will be sent to the Provider within 10 business days from the date of the decision.
10. Final notification of the appeals decision indicates that you have exhausted your appeals with Optima Health.

EXPEDITED APPEALS

An expedited appeal process may be requested by Providers or Members for urgent care claims and concurrent care decision/claims. A treating Physician with knowledge of the Member's medical condition will be permitted to act as the Member's Authorized Representative without the completion of an Authorized Designation Form for Expedited Appeals. Optima Health will not take punitive action against a Provider who requests an expedited resolution or supports a Member's appeal.

An urgent care claim is a claim for medical care treatment where using the standard Optima Health appeal procedure for making a decision would:

(a) Seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function; or
(b) In the opinion of a Physician with knowledge of the Member's medical condition would subject the Member to severe pain that cannot be adequately managed without the care or treatment in question.

A prudent layperson standard applies when making a determination on an urgent care claim, except where a Physician with knowledge of the Member's medical condition determines that the claim is urgent. Prudent layperson refers to a person that possesses an average knowledge of health and medicine and is without medical training.

A concurrent care decision/claim means a claim regarding a decision by Optima Health during the course of treatment to terminate or reduce benefits that it previously approved, or a request to extend the course of treatment already approved. When Optima Health has approved an ongoing course of treatment to be provided over a period of time or number of treatments, the Expedited Appeal process will be followed to allow sufficient time for the Member to appeal and obtain a determination before the benefit is reduced or terminated.

A request for an Expedited Appeal must explicitly state "**Expedited Appeal**". The process may be initiated by:

Telephone:	Call the Member Services Number on the Member ID card
Facsimile:	866-472-3920
Letter:	Optima Health **Appeals Department** P.O. Box 62876 Virginia Beach, VA 23466-2876

Expedited Appeal Process

- If a Physician with knowledge of a Member's medical condition contacts an Optima Health Representative and requests an Expedited Appeal the call will be transferred immediately to the Medical Care Services or Appeals Department.

- When a Member contacts Optima Health with a request to initiate an Expedited Appeal, the Member Services Representative will clarify the criteria for Expedited Appeal. If the Member agrees that the appeal does not involve an Urgent or Concurrent Care Claim, the Member Services Representative will direct the Member to follow the standard appeals process.

- If the Member verifies that the criteria for Expedited Appeal has been met or has questions regarding the criteria, the Member Services Representative will transfer the Member to the Optima Health Appeals Department.

- The Member or Member's Physician will have the opportunity to provide additional comments, documents, records or other information relevant to the appeal. The Appeals Coordinator will gather and present all information to ensure a full investigation of the substance of the appeal, including all the aspects of clinical care involved, to an Optima Health Medical Director who was not involved in the initial or reconsideration of the Adverse Benefit Determination.

- The decision on an Expedited Appeal shall be made by the Optima Health Medical Director, a peer of the treating Provider or a panel of other healthcare Providers with at least one Physician on the panel.

- An Expedited Appeal will be considered and notification of the decision by Optima Health will be made to the Member as soon as possible, but not later than one business day after all the necessary information is received and not later than **72 hours** from receipt of the request. Expedited appeals relating to a prescription to alleviate cancer pain shall be decided no later than **24 hours** from receipt of the request.
- If an expedited appeal is approved, notification will be made to the Member and treating Physician **immediately** either orally or electronically if urgent and will be followed by written notice within **three days**.

Denied Expedited Appeals

If an Expedited Appeal is denied, notification to the Member or treating Physician will be made electronically or written and will include information for requesting an External Review with the Bureau of Insurance (BOI). The Appeals Coordinator will provide the Member with the appropriate forms for filing an external review with the BOI. This information will be provided to eligible Members, which **excludes** Medicaid and FEHB Plans. Self-funded ERISA Plans should contact Members Services for External Appeals information.

If the BOI accepts an appeal for expedited review, the BOI will contact Optima Health and the Member by the most expeditious means available, including telephone, facsimile or electronic mail, of their rights to submit information and supporting documentation.

Members have the option to request review by an independent review organization in Emergency or life-threatening circumstances. Members must first exhaust Optima's internal appeal mechanism **UNLESS** it is determined that the time frame for completion of an expedited internal appeal would (a) seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function or (b) the denial of coverage is based on a determination that the recommended or requested healthcare service or treatment is experimental or investigational and the covered person's treating healthcare professional certifies in writing that such recommended or requested healthcare service or treatment would be significantly less effective if not promptly initiated. In an Emergency or life threatening situation described in (a) above, the Member, or the Member's Provider acting on the Member's behalf with the Member's consent, would not need to exhaust all internal appeals in this situation in order to file for an external appeal.

The expedited appeal application must be filed with the Virginia Bureau of Insurance immediately following receipt of Optima’s initial adverse determination or at any level of adverse appeal determination. If Optima Health failed to adhere to timeframe requirements on any level (Initial review or appeal), the Member is deemed to have exhausted Optima’s internal appeal process and may file an external review. Additionally, Optima Health has discretion to waive its internal grievance process and the requirement for a covered person to exhaust such process prior to filing a request for an external appeal or expedited external appeal.

If the expedited external appeal is not accepted on an expedited basis, and the Member has not previously exhausted Optima’s internal appeal, the Member may resume the internal appeal process and then may file for a standard external appeal within 120 days following receipt of the final denial letter.

MEMBER APPEALS

Member Appeals Procedure

When the Plan makes an Adverse Benefit Determination, the Member has the right to a full and fair review of the Plan's determination in accordance with the Plan's appeal procedure. Time frames for initiating a Member appeal vary by the Member's Plan. No Member who exercises the right to file an appeal with the Plan shall be subject to disenrollment or otherwise penalized due to the filing of an appeal.

With the exception of Expedited Appeals, all requests for Member Appeals must be submitted in writing. Members will be advised to submit their requests to:

Written Appeals and Complaints:
Optima Health Appeals Department
P. O. Box 62876
Virginia Beach, VA 23466-2876

Faxed Complaints:
866-472-3920

In Person:
Optima Health
4417 Corporation Lane
Virginia Beach, VA 23462

The Member may request an Expedited Appeal. The procedures for Expedited Appeals are the same for Members and Providers. See the Expedited Appeals section of this manual for detailed information.

Member Appeal Initiation Procedure

When a Member contacts the Plan to initiate an appeal, the Customer Service Representative will inform the Member that:

The Member Appeal Procedure is outlined in their Member materials and on the Member website. The Member has the right to designate a healthcare professional as an authorized representative to act on his or her behalf in filing an appeal. The Plan requires that a Designation Authorization Form be completed by the Member identifying the person authorized to act on his or her behalf with the exception of an Urgent Care claim. In such instances, the Plan will permit a healthcare professional to pursue a claim on behalf of the Member without the completion of the Designation Authorization Form.

A Member Appeals Packet is available to assist the Member with the Plan's appeal process. The Appeals Packet may be downloaded from the Member website. The Member or their representative has the right to submit written comments, documents, records or any other information relevant to the case.

Relevant information includes:

- The Appeal Request Form describing the services or procedures requested and an explanation of why the Member feels that the Optima Health decision was incorrect
- Office notes from Physicians that the Member has seen regarding the services or procedures in question
- Medical records from hospitals and other healthcare providers
- Physician correspondence
- Physical, occupational, or rehabilitative therapy notes
- Copies of bills the Member has received
- Any additional information the Member would like Optima Health to consider in reviewing their appeal

Upon Optima Health's receipt of the written request, additional medical information must be submitted within 10 days. Any documentation received after the tenth day may not be considered in the appeal review.