Appeals and Provider Dispute Resolution

Introduction

There are two distinct processes related to non-coverage (adverse) determination (NCD) regarding requests for services or payment: (1) Member Appeals and (2) Provider Dispute Resolution. An NCD for the purposes of this section is a decision by Optum to deny, in whole or in part, a request for authorization of treatment or of a request for payment. An NCD may be subject to the Member Appeals process or Provider Dispute Resolution process depending on the nature of the NCD, Member liability and your Agreement.

Care Advocacy decision-making is based on the appropriateness of care as defined by the Level of Care Guidelines, the Psychological and Neuropsychological Testing Guidelines, the Coverage Determination Guidelines, and the Behavioral Clinical Policies, as well as the terms and conditions of the Member's Benefit Plan.

The **Level of Care Guidelines,** the **Psychological/Neuropsychological Testing Guidelines,** the **Coverage Determination Guidelines,** the **Behavioral Clinical Policies** and the **Medicare Coverage Summaries** are available on **Provider Express** at **Guidelines/Policies & Manuals**. To request a paper copy of these guidelines, please contact Network Management at **1-877-614-0484**. Optum expects that all treatment provided to Members must be outcome-driven, clinically necessary, rational, evidence-based, and provided in the least restrictive environment possible.

Optum offers no financial rewards or other incentives for Providers, utilization reviewers or other individuals to reduce behavioral health services, limit the length of stay, withhold or deny benefit coverage.

Member Appeals Process

The Member Appeals process is available to Members, or their authorized representative (who may be their treating clinician at any level of care), in the event of a non-coverage (adverse) determination (NCD) when the Member may incur financial liability beyond the normal cost share or may experience a reduction in services requested. In the case of clinical reviews, Optum offers you the opportunity to discuss a request for services with an appropriately licensed peer reviewer.

If Optum issues a denial, in whole or in part, then such determination will be subject to the applicable Member Appeals process. The procedures for the Member Appeals process, including any applicable requirements for the filing and handling of an appeal, will be detailed in the Member rights enclosure which accompanies the NCD notice sent to you and the Member.

Member Appeals may be handled as urgent or non-urgent appeals. Urgent appeals apply in situations where, in your opinion, application of non-urgent procedures could seriously jeopardize the Member's life, health or ability to regain maximum functioning. For an urgent appeal, contact Optum immediately.

For an urgent appeal, Optum will make the review determination, notify you by telephone, and send written notification of the Member Appeal outcome to you and the Member or authorized Member Representative within 72 hours of the Member Appeal request or in accordance with applicable laws, whichever is sooner. By definition, urgent appeals are not available in situations where services have already been provided.

A non-urgent appeal must be requested within 180 calendar days from the Member's receipt of the NCD letter or in accordance with applicable laws, whichever is most beneficial to the Member. Optum will make a Member Appeal determination and notify you and the Member or the authorized Member Representative. This notification will be provided in writing within 15 calendar days from receipt of the request if services have not yet been received by the Member, or within 30 calendar days if services have already been received by the Member, or in accordance with applicable laws, whichever is sooner.

If you have received an authorization letter or a NCD letter and you wish to discuss any aspect of the decision with the Care Advocate or peer reviewer who made the decision, please follow the instructions in the letter and call the toll-free number provided in the letter. Authorization is not a guarantee of payment (except as required by law): payment of benefits is still subject to all other terms and conditions of the Member's Plan and your Agreement.

If you request a Member Appeal, it will be reviewed by someone who was not previously involved in the NCD, and who is not a subordinate of the person who made the initial NCD. The appeal reviewer will review all available information, including treatment records, in order to make a determination.

Appeals involving clinical determination
For an inpatient case involving a clinical determination, the appeal reviewer will be a board-certified psychiatrist or addiction-medicine specialist (from the same or similar specialty area as the treating clinician) with an active, unrestricted license. For an outpatient case involving a clinical determination, the appeal reviewer will be a doctoral-level psychologist or a board-certified psychiatrist with an active, unrestricted license.

Appeals involving non-clinical administrative determination
For non-clinical administrative appeals, the appeals reviewer will be an appropriately qualified Optum professional who was not involved in the initial NCD and who is not a subordinate of any person involved in the initial adverse decision.

Appeals decisions
If the appeal decision is to uphold an NCD, Optum will notify you and the Member, or the Member Representative, of the outcome and any additional levels of appeal that are available, as applicable.

When required by applicable law or Payor, the Member or you, as the authorized representative may appeal the NCD a second time if you are dissatisfied with the outcome of the first level appeal. The second level request must be made in writing within 60 calendar days (or as indicated in the first level appeal notification) of the date you received notification of the outcome of your first level appeal from Optum. You may initiate a second level appeal by contacting Optum at the address listed on the first level appeal notification.

You may continue to provide service following an NCD, but the Member should be informed of the NCD by you in writing. The Member or the Member Representative should be informed that the care will become the financial responsibility of the Member from the date of the NCD. In order for the Provider to receive payment from the Member, the Member must agree in writing to these continued terms of care and acceptance of financial responsibility. You may charge no more than the Optum contracted fee for such services, although a lower fee may be charged.

The consent of the Member to such care and responsibility will not impact the appeals determination, but will impact your ability to collect reimbursement from the Member for these services. If the Member does not consent in writing to continue to receive such care and Optum upholds the determination regarding the cessation of coverage for such care, you cannot collect reimbursement from the Member pursuant to the terms of your Agreement.

Provider Dispute Resolution Process

The Provider Dispute Resolution process is available to you, or your authorized representative, in a situation where the Member is not financially liable for the non-coverage (adverse) determination (NCD) issued by Optum, beyond the Member's normal cost share. That is, the payment dispute is between you and Optum, and regulated by the Agreement, rather than the Member's Benefit Plan. You, or your authorized representative, have the right to dispute any NCD made by Optum when the determination is adverse to you, rather than the Member.

The Provider Dispute Resolution process must be initiated in writing by contacting Optum at the address listed on the Provider Dispute Rights enclosure which accompanies the NCD notice and must include the following information:

- Member identifying information:
  - Name
  - Member Identification number
  - Date of birth
  - Address
- Each applicable date of service
- Provider identifying information:

  - Name
  - Tax identification number
  - Contact information
- Dollar amount in dispute, if applicable
- Any additional information you would like to have considered as part of the Dispute process, including records relating to the current conditions of treatment, co-existent conditions, or any other relevant information
- Your explanation as to why the NCD should be overturned

The Provider Dispute Resolution process is available for post-service requests. Disputes related to pre-service and other concurrent service requests are subject to the Member Appeals process previously described. To initiate a Provider Dispute, you must mail your request within 180 calendar days from the date you received the Provider Remittance Advice (PRA) from Optum. Disputes received outside of this timeframe will not be processed. Optum will notify you or your authorized representative of the dispute resolution in writing within 30 calendar days of the receipt of your request unless otherwise required by law.

In limited circumstances, when required by applicable law or Payor, you may dispute the NCD a second time if you are dissatisfied with the outcome of the first level dispute. The second level request must be made in writing within the timeframes specified in the first level appeal notification you received following the outcome of your first level dispute from Optum or in accordance with provisions of the Member's Plan. You may initiate a second level dispute by contacting Optum at the address listed on the first level dispute notification.

Arbitration

For non-clinical/contractual disputes, arbitration may be available. For additional information, please review the terms of your Provider Agreement for specific information to your rights.

In-network Providers may pursue arbitration, after exhausting all internal appeals. You will be required to submit an initial written request to meet and confer with your assigned Network Manager to review the circumstances surrounding your request for arbitration. The following items must be included in your written request:

1) Participating Provider name;
2) Documentation related to appeal denial(s);
3) Member Identification Number;
4) Date of Birth;
5) Address;
6) Applicable date(s) of service;
7) Address;
8) TIN;
9) Contact information (who is the Provider point of contact);
10) Dollar amount in dispute, if applicable;
11) Explanation of why the appeal should be overturned; and

12) Any additional information you would like to have considered in your initial request for arbitration

If the parties are unable to resolve the matter, your Network Manager will escalate the matter to Optum Legal and Compliance.