Disputes, Appeals and Grievances

Provider grievance on behalf of member for adverse medial determination—non-gatekeeper products

Geisinger Health Plan

Medical necessity adverse determination appeals for GHP non-gatekeeper products

A provider may only appeal a medical necessity adverse determinations for non-gatekeeper products (PPO and TPA with no-referral) on behalf of the member through the member grievance process. GHP medical management does not facilitate direct provider appeals for denials associated with non-gatekeeper plans. Providers should follow the grievance process outlined in this section to appeal a medical necessity adverse determination for non-gatekeeper products. If a provider attempts to contact GHP medical management in these instances, they will receive a notice that there is no provider appeal process available.

Grievance – a request by a member or a health care provider (with written consent of the member) to have the GHP reconsider a decision solely concerning the medical necessity and appropriateness of a health care service; a grievance may be filed regarding the decision that does any of the following:

- Disapproves full or partial payment for a requested health service
- Approves the provision of a requested health care service for a lesser scope or duration than requested
- Disapproves payment of the provision of a requested health care service, but approves payment for the provision of an alternative healthcare service

Filing a grievance on behalf of a member

The member, the member's legal or authorized representative, or a provider (with the written consent of the member) can file a formal grievance. Providers wishing to file a grievance on the member's behalf may call the GHP to request a consent form, which should be completed in full with the member signing in front of a witness who is also required to sign. The member may not file a separate grievance when a provider has filed a grievance. The member may rescind consent to the provider and continue with the grievance at the point at which the consent was rescinded. The member may designate a representative in writing at any time during the grievance process.

Providers may file a grievance by submitting the request in writing, with the completed consent form and indicating the requested outcome to;

Geisinger Health Plan
Appeals Department
100 North Academy Avenue
Danville, PA 17822-3220
FAX: 570-271-7225

First level grievance review process

Filing deadline

Requests must be received by the GHP within 180 days of the determination of coverage; once the provider has obtained written consent from the member to file a grievance, the provider has 10 days from the receipt of the adverse benefit determination to notify the member of the intention not to file a first level grievance.

Process

The GHP will send written confirmation of receipt of the grievance to the member, the member's representative (if one has been designated by the member) and the provider if the provider filed the grievance on behalf of the member. The notification will include the following:

- That the GHP considers the matter to be a grievance, rather than a complaint; the member, the member's representative or provider may question the classification of complaints and grievances by contacting the Pennsylvania Department of Health
- That the member may appoint a representative to act on the member's behalf at any time during the internal grievance process
- That the member, the member's representative or the provider that filed the grievance with the member's consent may review information related to the grievance upon request and submit additional material to be considered by the GHP
- That the member, the member's representative or provider may request the aid of a GHP appeal coordinator, who has not participated in previous decisions to deny coverage for the issue in dispute, in preparing the member's first level grievance

The First Level Internal Review Committee will review the grievance. The committee consists of a GHP Medical Director (licensed physician) who did not previously participate in any prior decision relating to the grievance/pre or post-service appeal and is not a subordinate of the person(s) who made the initial adverse benefit determination. The medical director will consider the full record including any aspects of clinical care involved and make an independent fair decision regarding the grievance/pre or post service appeal. The review will include the written input of a licensed physician or approved licensed psychologist in the same or similar specialty that typically manages or consults on the health care service, condition, performs the procedure or provides the treatment who has not been previously involved in the matter under review. The committee fully and fairly considers all available information relevant to the grievance, including any material submitted by the provider or the member, independent of previous reviewers when making a determination.

The First Level Internal Review shall complete its review and investigation and arrive at a decision within 30 calendar days of receipt of the grievance. The GHP will notify the member,

the member's representative and the provider of the decision of the First Level Internal Review Committee in writing within 5 business days of the committee's determination.

The written notification to the provider and the member shall include the following: a statement of the issue reviewed by the First Level Internal Review Committee, the basis for the decision, references to the specific GHP provisions on which the decision is based, if an internal rule, guideline, protocol or other similar criterion was relied on in making the decision and how to obtain these documents, if used, an explanation of the scientific or clinical judgment for the decision and an explanation of the procedure to file a request for a Second Level Grievance Review, as well as notification that if the member is a member of an ERISA group, the member has the right to bring civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA) once all administrative remedies have been exhausted.

The committee will make a recommendation of coverage for members enrolled in Pennsylvania Employees Benefit Trust Fund (PEBTF).

Second level grievance review process

Filing deadline

There is no filing deadline for the second level; once the PROVIDER has obtained written consent from the member to file a grievance, the PROVIDER has 10 days from the receipt of the decision letter for the first level to notify the member of the intention not to file a second level grievance.

Process

Upon receipt of a Second Level Grievance, the GHP will send the member, the member's representative and the provider an explanation of the procedures to be followed during the Second Level Review. The notification will include the following information:

- How to request the aid of a GHP employee who has not participated in any discussion of the issue in dispute in preparing the member's Second Level Grievance
- Notification that the member, the member's representative and the provider have the right to appear before the Second Level Internal Review Committee and that the GHP will provide the member, the member's representative and the provider with 15 days advance written notice of the time scheduled for review.

If the provider or the member is dissatisfied with the decision of the First Level Internal Review Committee, a voluntary Second Level Grievance Review may be requested in writing. The Second Level Internal Review Committee is comprised of 3 or more persons, one of which is a licensed physician, who did not previously participate in any of the decisions to deny payment for the service and shall be not subordinates of previous reviewers. The Second Level Internal Review Committee will include the written input of a licensed physician or approved licensed psychologist in the same or similar specialty that typically manages or consults on Geisinger health care service, condition, performs the procedure or provides the treatment, who has not been previously involved in the matter under review. The GHP will provide the provider and the member with at least 15 days advance written notice of the date and time scheduled for the meeting.

The GHP will make reasonable accommodation to facilitate the participation of the member, the member's representative and the provider by conference call or in person. The GHP will take into account the member's access to transportation and any disabilities or language barriers. If

the member, the member's representative or filing provider cannot appear in person at the second level review, the GHP will provide them with the opportunity to communicate with the review committee by telephone or other appropriate means.

Attendance at the second level review is limited to:

- Members of the review committee who are not employed by the GHP.
- Appropriate GHP representatives.
- The member or the member's representative, including any legal representative and/or attendant necessary for the member to participate in or understand the proceedings.
- The provider who filed the grievance with the member's consent.
- Applicable witnesses

Persons attending and their respective roles at the review shall be identified for the member and the member's representative.

The committee may not discuss the case to be reviewed prior to the second level review meeting. A committee member who does not personally attend the review meeting may not vote on the case unless that person actively participates in the review meeting by telephone or videoconference and has the opportunity to review any additional information introduced at the review meeting prior to the vote. The GHP may provide an attorney to represent the interests of the committee and to ensure fundamental fairness of the review and that all disputed issues are adequately addressed. The attorney may not argue the GHP's position, or present the GHP or the GHP's staff. The committee may question the member, the member's representative, the provider and the GHP's staff. The committee will base its decision solely upon the materials and testimony presented at the review. The proceedings will be recorded electronically and then summarized. The summary will be maintained as a part of the grievance record to be forward upon a request for an external grievance review.

The Second Level Internal Review Committee shall complete its review and investigation and arrive at a decision within 30 calendar days of receipt of the grievance. The GHP will notify the member, the member's representative and the provider of the decision of the Second Level Internal Review Committee in writing within five business days of the committee's determination.

The committee proceedings shall be informal, impartial and will fully and fairly consider all available information relevant to the grievance independent of previous reviewers, including any material submitted by the provider and the member to the GHP when making a determination.

The review will include the written input of a licensed physician or approved licensed psychologist in the same or similar specialty that typically manages or consults on the health care service, condition, performs the procedure or provides the treatment. The provider and the member have the right to request a copy of the written report of the physician or psychologist in the same or similar specialty and be provided a copy of the report at least seven days prior to the review date.

The written notification to the filing provider and the member shall include the following:

- A statement of the issue reviewed by the Second Level Internal Review Committee,
- The basis for the decision,
- References to the specific GHP provisions on which the decision is based, if an internal rule, guideline, protocol or other similar criterion was relied on in making the decision and how to obtain these documents, if used,
- An explanation of the scientific or clinical judgment for the decision, and

- An explanation of the procedure to file a request for an external grievance appeal, as well as notification that if the member is a member of an ERISA group, the member has the right to bring civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA) once all administrative remedies have been exhausted.

The committee will make a recommendation of coverage for members enrolled in Pennsylvania Employees Benefit Trust Fund (PEBTF).

Expedited grievance process

Should the member's life, health or ability to regain maximum function be in jeopardy by delay occasioned by GHP's standard review process, the provider or the member may file an oral or written request for an Expedited Grievance Review by telephoning GHP's Customer Service Team at (800) 447-4000 or by faxing the request to (570) 271-7225 or by writing to:

Geisinger Health Plan
Appeals Department
100 North Academy Avenue
Danville, PA 17822-3220

GHP will review the request to determine whether it meets medical criteria to initiate the expedited process. However, the provider may provide the GHP with a written certification that the member's life, health or ability to regain maximum function would be placed in jeopardy by the delay caused by GHP's standard review process. The certification must include a clinical rationale and facts to support the provider's opinion. Geisinger Health Plan will accept the provider's certification and provide an expedited grievance review.

Geisinger Health Plan may also expedite requests concerning admissions, a continued stay or other health care services if the member has received emergency services but has not been discharged from a facility.

Geisinger Health Plan may expedite the review if it is the provider's opinion that the member is subject to severe pain that cannot be managed without the care or treatment being requested.

It is the responsibility of the provider and/or the member to provide information to GHP in an expedited manner.

The Expedited Grievance Process will follow the process described above in the Health Care Provider-Initiated Grievance Second Level Grievance Review Process, with the following exceptions:

- Time frame is 48 hours for a decision.
- The hearing may be held telephonically if the member cannot be present in the short time frame. (All information presented at the hearing is read into the record.)
- If the GHP cannot provide a copy of the report of the same or similar specialist to the member prior to the expedited hearing, the GHP may read the report into the record at the hearing, and will provide the member with a copy of the report at that time.
- It is the responsibility of the member, the member's representative or the provider to provide information to the GHP in an expedited manner to allow the GHP to conform to the requirements of this section.

Notification to the filing provider and the member shall include the basis for the decision, references to the specific GHP provisions on which the decision is based and how to obtain these documents, if used, an explanation of the scientific or clinical judgment for the decision and an explanation of the procedure to file a request for an External Grievance Appeal as well as notification that if the member is a member of an ERISA group, the member has the right to bring civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA) once all administrative remedies have been exhausted.

The committee will make a recommendation of coverage for members enrolled in Pennsylvania Employees Benefit Trust Fund (PEBTF).

Third level grievance review process (external review)

Filing deadline

If the provider or the member is dissatisfied with the decision of the Second Level Internal Review Committee, the provider will have 10 days to notify the member of his/her intention not to pursue an external grievance and may appeal to the Department of Health by filing a request in writing to GHP within 15 calendar days of receipt of the notification of the Internal Review Committee's determination.

Process

Geisinger Health Plan will contact the Department of Health within five business days of receiving the external grievance request, which will assign an independent Certified Review Entity (CRE) within two business days of GHP's request to review the external grievance at no cost to the member. Geisinger Health Plan shall forward copies of all written documentation regarding the grievance to the CRE and notify the provider and the member of the list of documents forwarded to the CRE within 15 calendar days of the request for an external review. The provider and the member may supply additional information to the CRE, with copies to GHP, for consideration in the external grievance review within 15 calendar days of the request for an external review. The CRE will render its decision and provide a written determination to the provider, the member and the GHP within 60 calendar days of the filing for request of an external review.

The CRE will render an advisory opinion for members enrolled in Pennsylvania Employees Benefit Trust Fund (PEBTF).

- According to the summary plan document, members enrolled in PEBTF have the right to request an appeal to the trustees of the PEBTF within 30 days of the external review determination by submitting a written request to GHP. The trustees will review the appeal and notify the member of the decision within 60 days of the date of the appeal.

If a provider is requesting the external grievance, verification that the provider and the GHP have both established escrow accounts in the amount of half the anticipated cost of the review may be required. If the CRE's decision is against the provider in full, the provider will be responsible to pay the fees and costs associated with the external grievance review.

If a provider elects to appeal an adverse decision of a CRE, the provider may not bill the member for services provided that are the subject of the grievance until the provider chooses not to appeal an adverse decision to a court of competent jurisdiction.

Expedited Third Level Grievance Review Process (external review)

The provider who filed the Expedited Grievance Review with the member's written consent, and who is dissatisfied with the decision of the GHP's Expedited Grievance, may appeal to the Department of Health by filing a request orally or in writing with the GHP within two business days of receipt of the determination of the Expedited Grievance Review. The GHP shall submit the provider's request for an Expedited External Grievance Review to the Department of Health within 24 hours of receipt. The Department of Health, within one business day of receiving the request for an Expedited External Grievance Review, will assign a Certified Review Entity (CRE). The GHP shall be responsible to transfer documents regarding the review to the CRE for receipt on the next business day. The CRE shall have two business days to review and render a decision. The assigned CRE is required to review and issue a written decision to the member and the member's representative, the provider, if the Geisinger Health Care provider filed the grievance with the member's consent, the GHP and the Department of Health, within two business days. The Expedited External Grievance decision will be subject to appeal to a court of competent jurisdiction within 60 days of receipt of the Expedited External Grievance Review decision.

The CRE will make an advisory opinion for members enrolled in PEBTF.

- According to the summary plan document, members enrolled in PEBTF have the right to request an appeal to the trustees of the PEBTF within 30 days of the expedited external review determination by submitting a written request to the GHP. The trustees will review the appeal and notify the member of the decision within 60 days of the date of the appeal.

If a provider is requesting the Expedited External Grievance, verification that the provider and the GHP have both established escrow accounts in the amount of half the anticipated cost of the review may be required. If the CRE's decision is against the provider in full, the provider will be responsible to pay the fees and costs associated with the expedited external grievance review.

If a provider elects to appeal an adverse decision of a CRE, the provider may not bill the member for services provided that are the subject of the Expedited External Grievance until the provider chooses not to appeal an adverse decision to a court of competent jurisdiction.