Kansas City

2301 Main Street Kansas City, MO 64108 • (816) 395-2222 • BlueKC.com

Dear Provider Partner:

PROVIDER RESPONSIBILITIES FOR EXPEDITED MEMBER APPEALS

Blue KC wants to make sure you have the information you need to make expedited member appeals requests as smooth as possible for our Blue Medicare Advantage line of business.

WHAT YOU NEED TO KNOW

Who can appeal on behalf of the member?
Physicians can request a standard or expedited appeal of an adverse determination on behalf of their members. However, if not requested specifically by the attending physician, an Appointment of Representative (AOR) Form to submit an appeal on behalf of a Medicare member may be required. The AOR Form can be found online and downloaded here: https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS012207.

- Nurse Practitioners, Physician Assistants, nurses and office staff will require an AOR form to appeal on behalf of the member. If the appeal is requested on physician letterhead, the appeal will be accepted.
- The best practice is for the attending physician to sign the appeal request. This will prevent delays in processing the appeal.

What is an expedited appeal?
Expedited appeals for requested services pertain to those services in which the standard appeal time period (30 days for Part C, meaning medical services, procedures, facility admissions etc., and 7 days for Part B, which relates to drugs that are not provided by retail pharmacy under the Part D benefit coverage) could seriously jeopardize the member's life, physical or mental health or the member's ability to regain the maximum function. Blue KC must resolve an expedited review within 72 hours or as expeditiously as the member's physical or mental health requires once complete documentation has been received by Blue KC. An expedited appeal can be made by the member or provider on behalf of the member.

- The attending physician may submit an expedited appeal in writing or verbally.
    - Written appeals require the physician's signature or must be submitted on physician letterhead.
- Expedited appeals should state why the normal time period for an appeal could jeopardize the member's life, health or ability to regain maximum function. This language is required for verbal expedited appeals.
- Services that have been scheduled prior to obtaining authorization or completing the appeal process do not meet the definition of an expedited appeal.
- Submit documentation supporting the medical necessity of the requested service with your appeal.
- A member's request for appeal may be expedited if the requested services have not been provided and applying the standard timeframe could seriously jeopardize the life or health of the member. Blue KC may downgrade expedited requests that do not meet these criteria.

Here are examples of appeal requests that meet the expedited appeal criteria.

- Acute Rehabilitation Inpatient Admission or Continued Stay/Long Term Acute Care (LTACH) (continued care must be past the Quality Improvement Organization (QIO) appeal timeframe**).
- Skilled Nursing Facility Admission or Continued Stay (continued care must be past the QIO appeal timeframe**).

- Behavioral Health Inpatient Admission (i.e., homicidal ideation, suicidal ideation).
- Comprehensive Outpatient Rehabilitation Facility (continued care must be past the QIO appeal timeframe**).
- Services related to a Cancer diagnosis. Imaging, medications and surgery fall into this category.
- Transplant appeals.
- Spinal Imaging requests with Red Flag Indications. Red Flag indications for spinal imaging are intended to represent the potential for life or limb threatening conditions. Red Flag Indications are clinical situations in which localized spine pain and associated neurological features are likely to reflect serious underlying spinal and/or non-spinal disease and warrant exception to the requirement for documented failure of six weeks of provider-directed treatment. Please see eviCore Spine Imaging Policy SP-1.2 for more details of these Red Flag Indications.

**** QIO process occurs at the Utilization Management review level. The member is notified of the intent to discharge the member from an Inpatient stay (IM), Comprehensive Outpatient Rehab Facility, Home Health Service and Skilled Nursing Facility (NOMNC). As a part of this discharge, the member is provided discharge appeal rights. The member contacts the Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO) if the member thinks services are ending too soon. The BFCC-QIO decides this appeal. The member can request a 2nd level review with the QIO. Blue KC would review these members' appeal requests if the member missed the timeframe to appeal with the QIO. Otherwise, the QIO appeal decision is final.

QUESTIONS?

We value and appreciate you as our partner in providing quality care. If you have questions about any of this information, please call the Blue Medicare Advantage Provider Hotline at 1-866-508-7140.