

## Appeals and Provider Dispute Resolution

There are two distinct processes related to Non-Coverage (Adverse) Determinations (NCD) regarding requests for services or payment: (1) 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 Appeals process or Provider Dispute Resolution process depending on the nature of the NCD, Member liability and your Agreement. A final internal NCD is the upholding of an NCD at the conclusion of the Optum Appeals process.

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 Medicare Coverage Summaries, as well as the existence of coverage for the requested service in the Member's plan.

The **Level of Care Guidelines**, the **Psychological and Neuropsychological Testing Guidelines**, the **Coverage Determination Guidelines** and the **Medicare Coverage Summaries** are available at *Provider Express*. To request a paper copy of these guidelines, please contact Network Management at **(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.

### OptumHealth Behavioral Solutions of California Member Appeals Process

Our care advocacy process offers every Member, clinician and facility the opportunity to discuss a potential Non-Coverage (adverse) Determination (NCD) based on medical necessity with an appropriate peer reviewer at OptumHealth Behavioral Solutions of California (OptumHealth) before an NCD is made. You or the Member may request to discuss an NCD with us during the authorization of benefits process.

When a request for coverage of behavioral health services is not granted due to medical necessity or administrative decisions, the Member or authorized Member representative will be informed of the appeals process. Member Appeals can be requested as expedited (urgent) or standard (non-urgent). The appeal request should be submitted as soon as possible and must be received by OptumHealth within 180 days from receipt of the NCD.

Expedited/urgent (“Expedited”) appeals apply in situations where care is underway or has not yet been provided and the case involves “an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, potential loss of life, limb or major bodily function” (California Health and Safety Code, Section 1368.01(b)). Expedited/urgent appeals may be requested by the provider on behalf of the Member. In these cases, the OptumHealth peer reviewer (Appeal Reviewer) makes a reasonable effort to contact the treating provider within 24 hours of the receipt of the appeal request. We will make the review determination, notify the treating clinician by telephone, and send written notice of the appeal outcome to the treating provider (when applicable), and Member or authorized Member representative, as indicated, within 72 hours of the receipt of the appeal request. If the Appeal Reviewer is unable to reach the treating provider, the Appeal Reviewer will make a determination based on the available information. By definition, expedited appeals are not available in situations where services have already been provided.

When the situation is not of an urgent nature, a standard, or non-urgent, appeal may be requested. We will make an appeal determination and notify the Member or authorized Member representative in writing within 30 calendar days of receipt of the request.

A clinical peer who has not previously been involved in the NCD and is not a subordinate of any person involved in the NCD will review the appeal request and all available information, including treatment records in order to make a determination. For inpatient cases, the Appeal Reviewer will be a board-certified psychiatrist from the same or similar specialty area with an active, unrestricted California license. For outpatient cases involving a clinical determination, the Appeal Reviewer will be a doctoral-level psychologist or a board-certified psychiatrist with an active, unrestricted California license. Non-licensed appeals staff may review and make determinations for non-clinical administrative appeals.

If the appeal decision is to uphold an NCD, OptumHealth will notify the Member or Member representative of the outcome and any additional levels of appeal, if applicable.

Clinicians and facilities may continue to provide service following an NCD, but the Member must be informed of the NCD in writing. The Member or Member’s representative is informed that the care will become their financial responsibility beginning from the date of the NCD. The Member must agree to these terms in writing before continuing services can be provided. You may charge no more than the OptumHealth contracted fee for continuing services, although a lower fee may be charged. The consent of the Member to continuing care will not impact the appeals process as described above, but will impact your ability to collect reimbursement from the Member for these services. If the Member does not consent to continuing care in writing, and OptumHealth upholds the NCD regarding the cessation of coverage for such care, you cannot collect reimbursement from the Member.

## Optum Member Appeals Process

The Member Appeals process is available to Members, or their authorized representative, which 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 gain maximum functioning. For an urgent appeal, contact Optum immediately. For a non-urgent appeal, Optum will make the review determination, notify you by telephone, and send written notice of the 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 an 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 (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. For non-clinical administrative appeals, the appeals 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 state 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 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 the terms of your Agreement.

## **Independent Medical Review**

**For Members whose regulatory rights are governed by the Department of Managed Health Care (DMHC):** If the appeal involves coverage that was denied, modified, or delayed by Optum on the grounds that the service was not medically necessary, (in whole or in part), the Member has a right to request an external Independent Medical Review (IMR). Requests for IMR are made to the DMHC in accordance with California law. You or the Member must first appeal Optum's decision and wait for at least 30 calendar days before the Member requests external IMR. However, if the matter would qualify for an expedited decision, the Member may immediately request an external IMR following receipt of notice of denial. The Member may initiate this review by completing an application for external IMR, a copy of which can be obtained by contacting Optum. The DMHC will review the application and, if the request qualifies for external IMR, will select an external review agency and have the Member's medical records submitted to a qualified specialist for an independent determination of whether the care is medically necessary. There is no cost to the Member for external IMR. This review is in addition to any other procedure or remedies available to the Member and is completely voluntary. However, failure to participate in external review may cause the Member to give up any statutory right to pursue legal action against Optum, regarding the disputed service. For more information regarding

the external IMR process, please contact our Grievance Department at **(800) 999-9585**.

**For Members whose regulatory rights are governed by the California Department of Insurance (CDI):** If the appeal involves coverage that was denied, modified, or delayed by Optum on the grounds that the service was not medically necessary, (in whole or in part), the Member has a right to request an external Independent Medical Review (IMR). Requests for IMR are made to the California Department of Insurance (CDI) in accordance with California law. You or the Member must first appeal Optum's decision and wait for at least 30 calendar days before the Member requests external IMR. However, if the matter would qualify for an expedited decision, the Member may immediately request an external IMR following receipt of notice of denial. The CDI will review the application and, if the request qualifies for external IMR, will select an external review agency and have the Member's medical records submitted to a qualified specialist for an independent determination of whether the care is medically necessary. There is no cost to the Member for external IMR. This review is in addition to any other procedure or remedies available to the Member and is completely voluntary. However, failure to participate in external review may cause the Member to give up any statutory right to pursue legal action against Optum regarding the disputed service.

For more information regarding the external IMR process, please contact the Grievance Department at **(800) 999-9585**.

For Member's whose regulatory rights are governed by a state other than California, contact the number on the back of the Member's ID card for information regarding Independent Medical Review.

## OptumHealth Behavioral Solutions of California Provider Dispute Resolution Mechanism

A Provider Dispute is a contracted provider's written notice to OptumHealth Behavioral Solutions of California (OptumHealth) requesting review or reconsideration of a claim that has been denied, adjusted or contested; or seeking resolution of a billing determination or other contract dispute; or disputing a request for reimbursement of an overpayment of a claim. Provider Disputes are resolved through the Dispute Resolution Mechanism.

Disputes must be submitted in writing and must include the following:

- Provider's name;
- Provider's identification number;
- Provider's contact information;
- If about a claim, specific claim information including claim number, dates of service, procedure codes, amounts, etc.;
- If not about a claim, a detailed explanation of the issue;
- If about a Member, the name and identification number of the Member and a detailed

explanation of the issue.

The written dispute should be sent to the OptumHealth Behavioral Solutions of California Appeals Department:

OptumHealth Behavioral Solutions of California  
Attn: Appeals and Grievances Department  
P. O. Box 30512  
Salt Lake City, UT 84130-0512  
Telephone: **(800) 999-9585**  
Fax: (855) 312-1470

Providers may contact Network Management for guidance with the Dispute Resolution Process. Providers have up to three hundred sixty-five (365) days from the date of OptumHealth's action, inaction or incident causing dissatisfaction to submit a dispute. OptumHealth will send written acknowledgment to the provider within 15 working days of receiving the dispute. OptumHealth will send written notice of the resolution to the provider within 45 working days of receiving the dispute.

Any dispute submitted by a treating clinician on behalf of an enrollee is handled through OptumHealth's Member grievance and appeals system according to our policy and procedure. In such cases, the provider is deemed to be assisting the enrollee within the context of California Health and Safety Code, §1368.

Providers are offered one level of dispute review unless otherwise required by applicable law or regulation or contractual requirement. The outcome of the dispute is OptumHealth's final determination.

## Optum 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 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 benefit 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
  - 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 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 dispute from Optum. You may initiate a second level dispute by contacting Optum at the address listed on the first level dispute notification.