Appeals

Prior Authorization

Description

An administrative appeal submitted to us due to a claim denial for prior authorization due to lack of prior authorizations for services or for exceeding authorization limits. These appeals include a completed Universal Provider Request for Claim Review Form along with the following:

- A completed Universal Provider Request for Claim Review Form detailing all pertinent information with the necessary clinical documentation.
- Attach a copy of the claim and the remittance advice.
- Authorization-related appeals must demonstrate medical necessity and identify any additional clinical information to the Plan that was not previously provided or used in the initial decision.
- If prior authorization was required but not obtained, you must supply a written explanation of an extenuating circumstance that prevented you from contacting us for prior authorization or extending an existing authorization to cover the date(s) of service for a member’s treatment.
- If prior authorization was required and obtained, you must supply proof to the Plan that you followed the Plan’s prior authorization procedure. Proper supporting documentation includes a copy of your original information faxed/submitted to the Plan and relevant medical records. Also, please include the reference number received verbally or in writing from the Plan.

Examples of when BMC HealthNet Plan will review claims denied for lack of authorization in these situations:

- The member was added retrospectively to the Plan after the service was rendered.
- The member was added retrospectively to the Plan during a course of continuing treatment.
- The member has been referred retrospectively for same day services.
- Gaps in authorization exist for ongoing or continuing outpatient services and when extenuating circumstances exist.
- A service was provided (e.g., by a non-participating provider) that was urgent or emergent in nature and the service is covered by the Plan. However, there was an auto or manual administrative denial issued. Submit the medical documentation that supports the justification that the requested service was either urgent or emergent.

Other cases that support extenuating circumstances and retrospective review are appropriate. If one of these criteria is met, we will review the case and, if approved, we will adjust the claim. Only those services that meet medical necessity criteria which were in place on the date of service will be approved. This applies to all provider requests that do not meet medical necessity review criteria, level-of-care criteria, or medical policy to a Plan medical director. When the service is determined to be not medically necessary, the claim denial will be upheld.
**Appeal Response**
- If the appeal is received within the filing limit, BMC HealthNet Plan will review the appeal.
- A determination is made within 30 days following receipt of an appeal that is accompanied by the appropriate documentation.
- Appeals submitted beyond the filing limit will not be considered
- After the appeal has been reviewed a resolution letter will be mailed to the provider describing the decision.

**Second Level Appeal**
The Plan offers two levels of internal administrative review to providers. If the initial review results in an administrative denial, you have the opportunity to file a second administrative appeal to the Plan. An Administrative Appeals committee automatically reviews all second level appeals and decisions rendered by the Administrative Appeals committee are final decision by the Plan.

**Required and Supporting Documentation**
In addition to the information listed above, a copy of the denial along with additional supporting documentation for denied claim that specifically outlines the reason for a second level appeal.

**Second Level Appeal Response**
- If your request for a second level appeal is received beyond the Plan’s filing limit, the Plan will uphold the original denial.
- If the appeal is received within the filing limit, it will be reviewed by the Administrative Review committee who will provide a final decision on the claim.
- A determination is made within 30 days following receipt of an appeal that is accompanied by the appropriate documentation.
- After the appeal has been reviewed a resolution letter with be mailed to the provider describing the decision.

**Appeals Address**
BMC HealthNet Plan  
Attn: Provider Appeals  
P.O. Box 552852  
Boston, MA 02205