

12 Complaints, Grievances & Appeals

OVERVIEW

If the time arises when you disagree with any of Empire's policies or services or would like to request a review of an unfavorable determination, they may file a complaint, grievance or appeal. Please refer to the information below in order to follow the proper procedures.

PHYSICIAN COMPLAINTS

A complaint is an expression of dissatisfaction with any aspect of Empire's healthcare services not involving a plan decision.

If you are dissatisfied with any aspect of Empire's policies or practices relating to the delivery of services to covered persons, you may file a complaint with Empire. To do so, you must contact Empire's Physician Services by telephone at 1-800-552-6630, 8:30 a.m. – 5:00 p.m. EST, Monday – Friday or in writing at the address below. (No specific form for written complaints is required.)

Empire BlueCrossBlueShield
Attn: Physician Services
PO Box 1407
Church Street Station
New York, New York 10008-1407

The complaint and any supporting documentation submitted by you will be investigated by a qualified Physician Service Representative and the results will be communicated in a written decision to you within thirty calendar days of receipt of all necessary information.

This process applies to instances in which Empire is not being asked to review or overturn a previous administrative or medical management decision resulting in a claim denial, reduction in claim payment or denial of preauthorization or certification of covered services.

The processes used for those types of issues are described below.

GRIEVANCES

Grievances are requests to review unfavorable decisions (also called adverse determinations) not based upon medical necessity (e.g., benefit limitation, delay in service, subscriber contract exclusion, etc.). You must file a Level 1 Grievance within 180 calendar days from the date of our initial determination. Grievances filed after that date will not be considered.

Level One Grievances

To file a grievance, call or write Empire Physician Services at the same address and telephone number indicated above.

Empire will investigate and respond to Grievances within 30 calendar days of Empire's receipt of the grievance.

In the case of an urgent medical need where a delayed decision would significantly increase the risk to a patient's health, Empire will render a decision faster. In this situation you can request an Expedited Grievance. Expedited grievances will be responded to within 72 hours of Empire's receipt of the grievance.

Level Two Grievances

If you are dissatisfied with our decision on the Level 1 Grievance you may request a second Grievance. This is referred to as a Level 2 Grievance. You have 60 business days from the date of our decision on the initial Grievance to file a Level 2 Grievance.

The Level 2 Grievance will be reviewed by a representative not involved with the previous adverse determination at issue.

Level 2 Grievances are completed within 30 calendar days of receipt of the Grievance.

Expedited Level 2 Grievances will be responded to within 72 hours of Empire’s receipt of the Grievance.

Level 1 preservice appeals are completed within 15 calendar days of receipt of the appeal.

Level 1 postservice appeals are completed within 30 calendar days of receipt of the appeal.

Level of Grievance	Type of Grievance	Time frame to request Grievance	Time frame to respond
Level 1	Standard	180 calendar days from the date of our initial determination	30 calendar days
Level 1	Expedited	180 calendar days from the date of our initial determination	72 hours
Level 2	Standard	60 calendar days from the date of our initial Grievance	30 calendar days
Level 2	Expedited	60 calendar days from the date of our initial Grievance	72 hours

APPEALS

If Empire Medical Management determines that an admission, extension of a continued stay, or some other healthcare service is not medically necessary, you may request reconsideration or appeal the decision in the following manner.

The following can be appealed:

- Our initial adverse decision
- Our decision following a standard Level 1 appeal

The following can be reconsidered:

- An initial preservice or concurrent denial.

Empire offers two levels of standard appeal for providers.

An appeal is initiated by calling or writing to the Empire Medical Management Appeals Department at 1-800-634-5605, 8:30 a.m. to 5:00 p.m. EST, Monday – Friday, or by writing to:

Empire BlueCross BlueShield
 Attention: Appeals Department
 PO Box 1407
 Church Street Station
 New York, New York 10008-1407

Level 1 appeals must be initiated within 180 calendar days of our initial decision. Appeals filed after that date will not be considered, and you will receive a letter stating that the opportunity to file an appeal has been exhausted. The appeal should be accompanied by a letter stating why the determination is being appealed and why it should be overturned, as well as the information necessary to review it, such as the medical record.

Level 1 appeals are reviewed by a qualified medical professional, of same or similar specialty as the practitioner rendering the care, who was not involved with the initial determination.

A Level 2 appeal must be initiated within 60 business days from the date of our decision on the Level 1 appeal.

Level 2 appeals are reviewed by a physician, not involved in any previous determinations, who is of same or similar specialty as the practitioner rendering the care.

Level 2 preservice appeals are completed within 15 calendar days of receipt of the appeal.

Level 2 postservice appeals are completed within 30 calendar days of receipt of the appeal.

If we make a decision favorable to the person filing the appeal, written notification is sent stating that the initial denial decision has been reversed. If we make a final adverse decision upholding our prior decision, we will provide written notification that will include the clinical rationale upon which the appeal determination is based. The letter will also contain information and rights regarding filing a request for a Level 2 appeal to Empire. For preservice appeals, the appellant is notified of the appeal outcome verbally and in writing.

Expedited Appeals

You, the hospital, the member or his/her representative may request an urgent/expedited appeal to be implemented when the denial of coverage involves any of the following:

- cases involving continued or extended healthcare services
- requests for additional services for a patient undergoing a continuing course of treatment
- any case in which the member’s physician or healthcare provider believes an immediate appeal is warranted.

Note: There is **only** one level of expedited appeal.

Retrospective appeals are not eligible to be expedited.

We will provide reasonable access to a Medical Director within one business day of receiving notice of the request for an expedited appeal.

Our Additional Responsibilities

Level of Appeal	Type of Appeal	Time frame to request appeal	Time frame to respond
Level 1	Expedited	180 calendar days from the initial denial	72 hours
Level 1	Preservice	180 calendar days from the initial denial	15 calendar days
Level 1	PostsERVICE	180 calendar days from the initial denial	30 calendar days
Level 2	Expedited	N/A	N/A
Level 2	Preservice	60 business days from the first level appeal denial letter	15 calendar days
Level 2	PostsERVICE	60 business days from the first level appeal denial letter	30 calendar days

In addition to all of the previously stated responsibilities, we will also

- protect the confidentiality of all parties involved in the complaint and appeals process.
- include information regarding the next available level of appeal into all adverse responses to appeals.

External Reviews

Based on New York State Department of Insurance regulations, if services were denied based on medical necessity or a determination that they are experimental or investigational, subsequent to an appeal you may have the right to an external review. You can initiate an external review using the form Empire will send you when our final adverse determination is made.

Please note: Providers may request an External Review only when representing a member on preservice (prospective) appeal or themselves on a postservice (retrospective) appeal.