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Purpose

To provide denial documents to the Health Plan or QIO for appeal consideration. To provide additional information, upon request, from the Health Plan, once a decision has been made on the appeal.

When a member appeals a pre-service denial decision, the Health Plan will request a copy of the denial letter, the case notes, and the original prior authorization (PA) request. After the Health Plan makes a decision on an appeal, OptumCare is notified of the decision. Depending on the outcome, OptumCare may provide additional information to the Health Plan.

While the Prior Authorization Department does not complete concurrent reviews for previously approved and/or ongoing services, Medicare regulations state that members will have continued coverage for any covered services that were previously approved while an appeal is in process. Please refer to the local Market policy related to appeals.

Process Steps

#	Topic	Notes
1.	**Member Request**	If the Prior Authorization Department receives a call from a member (or their Representative), requesting an appeal, the member (or their Representative), will be warm transferred to the Health Plan Customer Service Department. If the Health Plan receives a written request for an appeal from a member (or their Representative), the Prior Authorization Department will be notified and will be responsible for creating and delivering an appeal packet back to the Health Plan. The response will be sent as quickly as possible (not to exceed 24 hours from receipt) to the Health Plan.
2.	**Health Plan/QIO Request**	Sends an appeal request via email to the LCD_UM in box. Mailbox Address: lcd_um@optum.com
3.	**OptumCare Clinical Administrative Coordinator**	The coordinator creates an appeals case. **Goal response times to send denial file to the Appeals Department.** These timeframes do not have exceptions for weekends and holidays: • Expedited Appeals- Respond as quickly as possible, within 2 hours of receipt.

		• Standard Appeals- Respond as quickly as possible, within 24 hours of receipt. Gather the following information: • Copy of the original request • Copy of the denial letter • Copy of the case notes (print and scan notes) • Copy of the clinicals CAC will send the denial file to the requestor and cc the Market via Secure Email or Secure Fax. Document in the case notes: • Date/time of receipt of the emailed request for PA File • The name of the Health Plan Appeals Coordinator. • The date/time the requested information was sent. • How the information was sent (fax or email)
4.	**OptumCare Clinical Administrative Coordinator**	Receives notice of the Health Plan's appeal decision. Will document the appeal determination in the case notes, including the decision/rationale from the health plan • If the decision is to overturn the original denial of the request, CAC will generate an approval letter and send it to the Designated Health Plan via Secure Email or Secure Fax. **These timeframes are required with no exception for weekends and holidays:** o Expedited Appeals- Respond as quickly as possible, within 2 hours of receipt of the Health Plan appeal decision. o Standard Appeals- Respond as quickly as possible, within 24 hours of receipt of the Health Plan appeal decision. o **NOTE:** If there is a system or letter delay, the coordinator will send a copy or print screen of approved authorization for services in lieu of an approval letter. • If the decision is to uphold the original denial of the request, the denial case is left intact. Forward the Health Plan decision email to the local Market