



PRACTITIONER/PROVIDER APPEAL PROCEDURE

In keeping with Insurance Division Regulations, NCQA standards ERISA laws and contractual obligations, Mesa Mental Health (MMH) has an appeal process that allows practitioners/providers to question decisions affecting the delivery of behavioral health care services and to request a second review of the issues involved. This document explains the process to be followed if you are dissatisfied with the decisions reached regarding the care or service referenced in this Explanation of Benefits (EOB) or denial letter. **Please note: Some regulatory bodies require you initiate your appeal within six months of the date on the EOB or denial letter.**

Who may initiate the appeal process?

Any member, guardian, practitioner or provider acting with the member's written permission can request an appeal.

How does a practitioner/provider initiate the appeal process?

Simply call the UM department locally at **816-6709** or the QM department via the toll free number, **1-800-583-6372**, and tell the customer service representative who answers the phone that you would like to initiate an appeal. You will be instructed where to send the additional information you would like considered in reviewing your case (**PO Box 90607, Albuquerque, NM 87199-0607**).

If you prefer to do this in writing, please send a letter asking to have an internal review of the decision you are unhappy with and why you feel the decision should be changed. Be sure to include additional documentation that supports your request. Send to: **Mesa Mental Health, Attn: QM Dept., PO Box 90607, Albuquerque, NM 87199-0607** OR you may fax it to **(505) 816-6702, Attn: QM Dept.**

What will happen next?

Mesa Mental Health will send you a receipt letter acknowledging your request for an internal review within one to three working days depending upon the urgency of your case. This letter will let you know how to contact someone at Mesa Mental Health should you have additional questions about the process.

NON-MEDICAL ISSUES SUCH AS CLAIMS PAYMENT, BENEFIT LIMITATIONS, NETWORK ISSUES AND ADMINISTRATIVE PRACTICES:

- A decision will be reached, after reviewing the additional information, within three to twenty (20) working days of submitting your request depending upon type of review needed.
- You will receive a decision letter within twenty (20) working days of MMH receiving the request for an appeal. If the **information needed** and

requested for a decision to be made **is not received** within the allotted timeframe, **the appeal will progress** without the additional information.

MEDICAL CARE ISSUES INVOLVING MEDICAL NECESSITY, APPROPRIATE LEVELS OF CARE AND BENEFIT LEVELS:

Expedited Cases:

- If the issue is urgent or emergent, you will be notified by phone or fax that MMH is in receipt of your request for an expedited appeal.
- A decision will be rendered within 72 hours of MMH receiving the request.
- You will be verbally notified of the decision within one working day of the decision being made. A letter to you and the member will follow the phone call within two working days of the decision being made.

Standard Cases:

- For standard utilization management appeals, you will be notified in writing within one working day of MMH receiving your request for an appeal.
- A decision will be made within twenty (20) working days of receiving the request. If the additional information needed cannot be obtained within the allotted timeframe, an automatic denial will be issued.
- You will be notified of the decision by phone within one working day of the decision being made. A letter to you and the member will follow the phone call within three working days confirming the decision and instructing the member on what other options they have available

What will this letter say?

The written decision letter will tell you:

- The name, title and qualifications of the person conducting the review
- What the reviewer understood the issue to be and the facts involved
- A clear and complete explanation of the reasons behind his/her decision
- Identification of the documents used to make the decision
- A statement that says the decision is binding unless the member submits a request for a Grievance Hearing to Blue Cross Blue Shield of New Mexico (BCBSNM) within ten working days of receiving the letter
- An explanation of how to request a Grievance Hearing, the name, title and phone number of a contact person at BCBSNM, and any required forms.

What if I am unhappy with the Mesa Mental Health Appeals decision?

The **member** has the right to request a grievance hearing from the insurance carrier. For Blue Cross Blue Shield of New Mexico and HMO New Mexico members this means submitting a request within ten working days of receiving the MMH decision letter to: **Blue Cross Blue Shield New Mexico, Attn: Appeals Unit, QMID, PO Box 27630, Albuquerque, NM 87125-7630; 1-800-205-9926, option #4 or option #7 or locally at 505-816-2226.**