October 2018

Medical necessity appeals on behalf of members

Background: In the past, Healthy Blue has accepted appeals without signed member consent as a courtesy to providers. In order to comply with the Medicaid and CHIP Managed Care Final Rule enforced by the Louisiana Department of Health, effective December 1, 2018, Healthy Blue will no longer accept provider appeal requests on behalf of a member without signed member consent.

Filing an appeal on behalf of a member

A provider may file an appeal on behalf of a member if the provider has the member's written, signed consent. Please note, a signed consent to treatment is not a consent to appeal. A provider who files an appeal with the written consent signed by the member must follow all requirements for a member appeal, including timely filing.

Our goal is to handle and resolve every appeal as quickly as the member's health condition requires. Our established time frames are:

- Standard resolution of appeal: 30 calendar days from the date of receipt of the appeal
- Expedited resolution of appeal: 72 hours from receipt of the appeal
    - If your request is deemed to be non-expedited, the standard 30-day timeline for resolution will apply.

Appeals may be filed orally or in writing within 60 calendar days of the *Notice of Action*. Requests can be made in the following ways:

- By mail:

  Healthy Blue
  Central Appeals and Grievance Processing
  P.O. Box 62429
  Virginia Beach, VA 23466-2429
- By fax: **1-888-873-7038**
- By telephone: **1-844-521-6941**

What if I need assistance?

If you have questions about this communication or need assistance with any other item, contact your local Provider Relations representative or call Provider Services at **1-844-521-6942**.

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