Provider Appeals

Health Alliance's appeals process for physicians, healthcare professionals and facilities for dates of service August 1, 2021 and after has one level of formal appeal after first asking for an informal inquiry on a denied claim. Both informal and formal appeals will need to be entered on our online Provider Inquiry Portal located at Provider.HealthAlliance.org. Please note, requests to obtain an appeal due to lack of prior authorization will only be granted for extenuating circumstances described in the informal inquiry request.

The purpose of an appeal is to escalate a reprocessing inquiry decision or bring immediate attention to a critical issue. An appeal should not be the first attempt at communication between the parties for any given issue. You may only appeal for specific reasons outlined in your provider agreement. These include contractual allowances, investigational services, clinical editing, no prior authorization and other specific reasons.

We'll always try to resolve provider-initiated inquiries through the course of normal operational interactions and our informal inquiry resolution process. Providers must initiate informal inquiries within 90 days of the original denial. To clarify, we define provider informal inquiries as the first contact initiated by the provider to our staff. We accept these inquiries through our Provider Inquiry Portal. To ensure your initial inquiry is handled in the most timely manner please provide as much detail for why an appeal of the denied claim is being pursued.

If you're not satisfied with the claims processing, administrative determination or outcome of the online claims reprocessing inquiry, as mentioned above, you may submit a formal appeal to us within 90 days from the original denial, unless otherwise stated in your contract. To submit a formal appeal, you must complete the Provider Appeal form located at Provider.HealthAlliance.org. Once the appeal form has been completed, please submit it through our online provider inquiry portal.

If you have any questions regarding the appeals process, please contact your provider relations specialist. We're always happy to help.

Member Complaints and Appeals Procedure

Health Alliance is committed to promoting member satisfaction. All Health Alliance members have complaint and appeal procedures specific to their plan type which they may follow if they encounter a problem or concern which is not resolved to their satisfaction through routine contact with providers or Health Alliance staff.

SECTION 5 APPEALS

There may be situations when it is necessary for Health Alliance to contact physicians or other providers to investigate member concerns. It is essential that any requests for information are responded to quickly and accurately to ensure response to members within the required time frames.

If a member has a complaint or concern regarding their health benefits, please encourage the member to contact the Health Alliance Customer Service Department at the number on the back of their ID card.

Types of Appeals

With permission from a Health Alliance-covered patient, a provider may appeal a decision made by Health Alliance on any issue with respect to the member. The appeals process varies by type of appeal—medically related versus non-medically related. Medically related appeals concern a prospective (pre-service) or retrospective (post-service) denial of coverage due to the treatment or service not meeting the Health Alliance medical necessity requirements. Non-medically related appeals encompass eligibility, benefit coverage and/or procedural issues.

To make an appeal on behalf of a member, call (800) 500-3373.

Medically Related Appeals

For the majority of our plans, medically related appeals have two levels of review: internal review and external review. (Certain plans may have different levels of appeal.)

Internal Review: An internal review is conducted by a clinical peer not involved in the original denial of a coverage decision. Once all necessary information for review of an appeal has been obtained, Health Alliance has 15 or 30 days (depending upon the plan) to issue a decision for non-urgent pre-service appeals and 15–60 days to issue a decision for post-service appeals.

Information used in the internal review can include medical records, a written statement from the provider supporting the treatment or service, and copies of research articles or references used to recommend treatment. The provider and the member will be notified of the results of the internal review by mail and phone.

External Review: For plans that have an external review option, the external review is conducted if the provider and/or the member are not satisfied with the outcome of an internal review. A provider or member may request review

by an external review organization (ERO) within four months (for most plans) of receiving written notice of the internal review decision.

A request for an external review is made to Health Alliance or the Illinois Department of Insurance, depending on the member's plan type. All parties involved in the appeal will be given a copy of the external review process and instructions on how to file an adverse appeal letter. There is no cost to the member or provider for the external review. All parties will be notified of the decision from the ERO. If approved, coverage will be provided immediately.

Expedited Review: If a provider feels a review is urgent, they may contact Member Relations at (800) 500-3373. A decision will be rendered within 24–72 hours depending on the member's plan type.

Non-Medically Related Appeals

Non-medically related appeals will be reviewed by administrative personnel who are trained to assess coverage and benefit issues. Once all necessary information for review of an appeal has been obtained, Health Alliance has 15–30 days to issue a decision for pre-service appeals and 15–60 days to issue a decision for post-service appeals. The provider and the member will be notified of the decision regarding a non-medically related appeal by mail. These appeals are not reviewed by EROs.

Non-Retaliation

Health Alliance will not retaliate against a provider for advocating for appropriate health care services for our members.