



SUBJECT: Provider Appeals from Adverse Contract Actions and Denials of Participation in BCBSVT Networks (including Related Reporting)	
BUSINESS OWNERS: Legal Services, Quality, & Provider Contracting	
APPROVED BY  <hr/> Dawn Schneiderman Vice President & Chief Operating Officer  <hr/> Joshua Plavin, MD, MPH, MBA Vice President and Chief Medical Officer	ORIGINAL EFFECTIVE DATE: 10/01/05
	LAST REVISED: July 2021
	NEXT REVIEW DATE: As needed
APPLIES TO: All Commercial Lines of Business and VBA Medicare Advantage	
REGULATORY / ACCREDITATION LINKS: State of Vermont Rule H-2009-03 Standards: 5.2A – 5.2J National Practitioner Data Bank Guidebook POLICY LINKS: BCBSVT Practitioner Credentialing Policy BCBSVT Facility Credentialing Policy BCBSVT Ancillary Provider Enrollment Policy	

I. Policy

Blue Cross and Blue Shield of Vermont and The Vermont Health Plan, LLC (“Plan”) allow for provider appeals based on Plan actions that limit or prohibit a provider’s participation in the Plan’s network.

II. Scope

This policy outlines the appeals process with respect to actions by the Plan that impact a provider’s initial or continued participation in the network.

This policy does not cover appeals of benefit-related denials. For that process, please consult the Provider Handbook or the Plan's Claims Appeal policy. Please note that there is no appeal process for denials based on failure to obtain prior approval, failure to meet timely filing requirements, or based on claim-edit denials. For inquiries about these non-appealable denials, or concerns about reimbursement rates, please contact customer service or your provider relations consultant.

III. Procedure

A. Appeals Procedure

1. Appealable Events (also referred to as Adverse Actions). A provider may request an appeal if the Plan:
 - a. Provides notice of an intent to reduce, suspend, or terminate a participating provider's participation or contract with the Plan; or
 - b. Denies participation in the Plan's network.
2. Timeframe. The provider must request an appeal in writing within thirty (30) calendar days of the written notice of denial, termination, or limitation. Failure to request an appeal within this timeframe will constitute a waiver of the right to appeal. The Plan will consider an extension of the deadline if the provider demonstrates good cause for not meeting the deadline due to circumstances beyond the provider's control.
3. Submission Requirements.
 - a. The request must be directed to the Plan's provider contracting department (ProviderContracting@bcbsvt.com or by mail to Provider Contracting, BCBSVT, P.O. Box 186, Montpelier, VT 05601-0186).
 - b. The request must include a short and plain statement of all the reasons why the Plan's decision was in error. Each assertion of error must be supported by documentation.
4. Appeal Information and Requests for Additional Information. After receiving an appeal request, the Plan will supply the provider with a packet of information upon which the adverse action was based. This packet will include a copy of the provider's contract(s) (if applicable), applicable policies and procedures, minutes of any meetings where the decision about the adverse action was made, and any audit results (if applicable). If the provider believes the provider requires additional information beyond what is included in the packet, the provider may submit such a request to the Plan's provider contracting department. The Plan has the discretion to grant or deny the request; if the request is granted, the Plan will determine the scope of discovery that will be allowed.
5. Provider Status During Appeal.

- a. For denials of network participation, the provider will be considered as non-participating during the appeal process.
 - b. For appealable events involving participating providers, the termination or limitation at issue will be stayed pending the outcome of the appeal except in cases where:
 - i. Immediate termination is required (for example, in the case where the provider does not have a license or has been excluded from federal programs) or
 - ii. The Plan determines, in its sole judgment, immediate termination or limitation is necessary during appeal to protect member's interests, including health and safety or to prevent the continuation of fraudulent or criminal activity.
 - c. Note that per the provider's contract, the Plan may summarily suspend the participation or contract of any provider to conduct an investigation to determine whether that provider poses a threat to the safety, health, or well-being of Plan members. The provider will be notified as soon as possible by telephone, as well as in writing, of an immediate suspension. If the Plan determines the provider does pose a threat, Plan may extend that suspension during the appeal process. If Plan determines provider does not pose a threat, the summary suspension of the provider will be lifted, and any suspended claims will be processed accordingly.
6. Hearing Upon Showing of Good Cause. Appeals will be determined on the basis of the written record. A provider can request an in-person hearing, after receiving the packet referenced in paragraph 4, above, if the provider is a currently participating provider and demonstrates to the Plan's satisfaction that an in-person or telephonic hearing is necessary because evidence relevant to the provider's claim is only available through live testimony. The Plan will respond within five (5) days of the provider's request. If the Plan does not find that a hearing is warranted, the appeal will proceed through a review of only written documentation.

7. Review Panel

- a. Plan will appoint an appeals officer to the case and recruit a panel to consider the appeal.
- b. The voting members of the panel will consist of:
 - i. Plan senior medical director (or designee) and
 - ii. Two providers, at least one of which has the same or similar specialty as the provider requesting the appeal.
- c. The appeals officer will be a member of the Plan's legal department (or designee) who will manage administrative issues relating to the appeal and facilitate the

review. The appeals officer will not participate as a voting member of the appeal panel. The appeals officer will not have had significant involvement with the investigation of the provider or the decision to take action against the provider, and the appeals officer will not have any personal relationship or prior dealings with the provider.

- d. Once the appeals officer and panel are appointed, the appeals officer will provide notice to the provider of the names and specialties of the members of the appeal panel.
 - e. The provider may object to the participation of a member of the appeals panel if provider can demonstrate the panel member has a conflict of interest or personal bias that would prevent the panel member from reviewing the case fairly. The provider must object within fifteen (15) days of receipt of the notice described in (d), above. The Plan will respond within five (5) days of receipt of the provider's objection. If the Plan agrees to replace one panel member, the Plan will work as expeditiously as possible to find a substitute panel member.
8. Hearing Preparation and Scheduling. If Plan finds that the provider has demonstrated an in-person or telephone hearing is warranted, the process for preparing and scheduling the hearing will occur as follows:
- a. Within fifteen (15) days of finalizing the hearing panel, the Plan will provide notice of the appeal hearing date. The hearing will take place no less than thirty (30) days after the notice is provided. The notice will list the names of any witnesses the Plan intends to call and any other participants in the appeal hearing. The names of individuals whose involvement will be limited to providing administrative support to the proceedings need not be included. The Plan will make reasonable scheduling accommodations requested by the provider.
 - b. Within five (5) days of receipt of the hearing notice, the parties will each submit a chronology/timeline of events relevant to the case and, if not already provided, the provider will submit a list of witnesses the provider intends to call at the hearing. If either party wishes to present additional written documentation not contained in the packet provided by the Plan or in any materials submitted by the provider, this information will be submitted to the appeals officer along with the chronology/timeline. The parties may submit a jointly-prepared chronology and record if desired. The parties will indicate whether they prefer an in-person hearing or a hearing by teleconference. Each party will indicate whether more than one hour is required for presentation of testimony and cross-examination of the other party's witnesses.
 - c. Any objections to the submitted chronologies or documentation must be submitted within five (5) days. The appeals officer will make determinations on any objections and any requests for additional time for testimony, within five (5)

days of receipt.

- d. The appeals officer will distribute copies of the hearing documents described in paragraph (b) above to the hearing panel in advance of the hearing.
- e. Any requests to deviate from the timeframes or procedures above will be considered at the appeals officer's discretion.

9. Hearing Procedure.

- a. The provider has the burden of proving, by a preponderance of the evidence (i.e., more likely than not) that the Plan's decision was inconsistent with the provider contract or the Plan's policies and procedures.
- b. The provider may be represented by legal counsel or any other individual of his or her choice. The Plan may be represented by legal counsel or any other individual of its choice.
- c. The provider and provider's representative may participate in the hearing in person or by teleconference.
- d. Both parties may call witnesses, so long as those witnesses were identified in writing prior to the hearing, as described in paragraph 8, above.
- e. The panel will first hear evidence and testimony presented by the Plan, then evidence and testimony presented by the provider.
- f. Each party will be allowed one (1) hour for presentation of witness testimony and cross-examination of the other party's witnesses, unless otherwise agreed.
- g. The panel may ask questions of the parties or witnesses during the hearing.
- h. The parties will be allotted an additional fifteen (15) minutes each to make a summary argument to the panel.
- i. The appeals officer will record the hearing. The provider may request a copy of the recording of the hearing upon payment of all reasonable charges associated with its preparation. The Plan will not supply a transcript, but the Plan will have a transcript prepared upon provider's request if provider pays for its preparation.
- j. If a party wishes to submit a final written statement for review by the panel, that statement is due within five (5) days after the hearing.

10. Review and Decision.

- a. Where the appeal consists of a review of written documentation only, the panel will review the materials (including the packet the Plan supplied to the provider as well as any materials submitted by the provider). If needed, the panel will request any additional information from the provider and will specify a date by when the provider must supply the additional information. The panel will conduct a full review of all materials received and will vote to make the final decision on whether the Plan's decision to take adverse action against the provider should be reversed or upheld. The decision document will include the vote of each of the panel members if the decision is not unanimous. The panel, as a whole or the majority voters, shall include a brief summary of the basis for the decision. A dissenting voter may include a brief explanation of the rationale for the dissenting vote. The decision will be issued within fifteen (15) days of the panel receiving all relevant materials.
- b. Where the appeal involves a hearing, the panel and appeals officer will convene within ten (10) days after the hearing has concluded to review evidence and testimony. The panel will vote to make the final decision on whether the Plan's decision to take adverse action against the provider should be reversed or upheld. The decision document will include the vote of each of the panel members if the decision is not unanimous. The panel as a whole, or the majority voters, shall include a brief summary of the basis for the decision. A dissenting voter may include a brief explanation of the rationale for the dissenting vote. The decision will be issued within fifteen (15) days of the conclusion of the hearing.

11. Post-Appeal Arbitration.

- a. If the provider's contract allows, the provider may elect to arbitrate the decision described in paragraph 10. If the decision on appeal upheld the Plan's decision to terminate the provider's termination, the Plan may proceed with termination before the arbitration process begins.
- b. The provider must initiate arbitration within sixty (60) days of the decision on appeal. Initiating arbitration means submitting a written notice to the Plan that articulates why arbitration is appropriate and proposes a list of arbitrators. Failure to initiate the arbitration process within this timeframe constitutes a waiver of the option to arbitrate.
- c. Plan will respond with its selection of an arbitrator within one (1) week of receipt of the list from provider.
- d. Once the arbitrator has been selected, the provider must file a full copy of the record submitted to the hearing panel along with a statement of claim with the arbitrator. The Plan will have seven (7) days to respond to provider's claim. No additional filings or evidence will be allowed, and each party will be responsible

for their own costs associated with the arbitration.

- e. To overturn the Plan's decision, the arbitrator must conclude the Plan's decision was arbitrary and capricious. The arbitrator shall give deference to the Plan's decision.
- f. The arbitration will consist of a review of the record, which includes the written decision on the appeal, the packet of information provided by the Plan and any additional materials presented (at the hearing or through the document review process). No additional evidence will be considered unless the provider can show good cause. The scope of the arbitration will be to determine whether there were facts or arguments that reasonably supported Plan's decision.

12. Reporting.

- a. General. The Plan will report results of investigations, credentialing committee decisions, and appeal results to the National Practitioner Data Bank (NPDB) and/or the practitioner licensing board as required by law.
- b. NPDB Reporting. Upon completion of the appeals process and within ten (10) days of the Plan's final action (in the case of contract termination, the final action will be the date of termination from the provider network), the appeals officer or representative of the legal department (or designee) will notify the Plan's designated NPDB Integrated Query and Report System (IQRS) administrator of the final disposition and basis for decision. The IQRS administrator will determine whether a report to the NPDB is required by law or is otherwise appropriate. If a report is required or appropriate, the IQRS administrator will gather sufficient background information about the case to determine the correct action and basis codes to be entered into the IQRS and will draft the required narrative to be entered into the IQRS. The appeals officer or representative of the legal department (or designee) will review the draft report prior to submission. The IQRS Administrator shall be responsible for making any subsequent updates to the report if subsequent events cause the Plan to change the provider's status.
- c. Licensing Board Reports. In some cases, including those involving provider quality issues related to provider competence or unprofessional conduct, the Plan must also report the adverse action to the applicable state licensing authority. The IQRS administrator, in consultation with the appeals officer or representative of the legal department (or designee), will determine whether such reporting is necessary and, if so, submit the report. This obligation is usually satisfied by forwarding a copy of the IQRS report verification document to the licensing authority.