



Health Service System

CITY & COUNTY OF SAN FRANCISCO

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Date: October 23, 2009

To: Board of Supervisors

Cc: Supervisor Alioto-Pier

From: Catherine Dodd, Interim Director, HSS

Subject: Blue Shield Denials and
System Policies on Assisting Denied Members
Reference 20090922-001

Health Service System members enrolled in the Blue Shield HMO are protected by three separate grievance processes. These processes are administered independently by Blue Shield, the Health Service System and the California Department of Managed Health Care. A member grievance must first be made to the HMO. If Blue Shield returns a grievance decision that is unsatisfactory to the member, that member can then ask HSS and/or the State to review the grievance. Each of these three entities allows for a grievance to be expedited in certain situations, such as when a member's health is in grave danger. These multiple avenues for grievance review ensure that the initial decision of the HMO can be contested and, when necessary, overturned by the Health Service System or Health Service System Board or the State. Health Service System members are informed about their right to file a grievance with their HMO. This information about the grievance process is included in printed enrollment materials and available online. In addition, HSS members can contact HSS Member Services by telephone for information about the grievance processes.

For this report, Health Service System reviewed member grievances filed against the Blue Shield HMO from August 2008 to August 2009. Grievances were submitted for appeals of clinical and nonclinical denials, complaints or potential quality issues. Appeals, which are denials for coverage, go through the grievance process and are the subject of this report. However, members also make complaints to Blue Shield when they experience communication issues, excessive wait times or when they perceive that the care they received from their provider was poor or inadequate.

The appeals data indicates:

- the level of member appeals filed against Blue Shield by HSS members, at 7.2 per one thousand members, is in line with Blue Shield's entire HMO business, at 7.7 per thousand members;
- more appeals were filed for non-clinical denials, at 61%, than for clinical denials, at 39%;

- 73% of the appeals for clinical denials were for procedures deemed medically unnecessary by a physician or medical group;
- the overturn rate of appeals, at 37%, is lower than the overturn rate for Blue Shield's entire HMO and PPO business, reflecting the proportionally larger number of non-clinical appeals filed by HSS members;
- HSS members who received an unfavorable decision from the HMO on their appeal can take advantage of HSS and State processes for contesting those decisions.

DATA ON BLUE SHIELD DENIALS

From August 2008 to August 2009, an average 45,349 HSS members were enrolled in the Blue Shield HMO. (The exact number of enrollments varies from month to month over the course of a year; we took the 12 month average for the purpose of this data analysis.) During those 12 months, 326 Blue Shield appeals for denial of coverage were filed by HSS members, or 7.2 per thousand members, which is in line with the appeals filed against Blue Shield's entire HMO member population, at 7.7 per thousand members.

Out of the 326 appeals filed, 128 were clinical appeals and 198 were non-clinical appeals. Clinical appeals may be filed when a member is denied a medical service or has been denied payment for a medical service. Non-clinical appeals are filed when a member is contesting other administrative or contractual issues related to their benefits. Most of the clinical appeals, or 105 out of the 128, were for procedures denied because they were deemed medically unnecessary by a doctor or medical group. The 198 non-clinical appeals filed during the period had to do with disputes about contracted benefits, the HMO service network and the pre-authorization process.

Appeal	No. of Filings
CLINICAL	
Benefit Interpretation	9
Emergency Services	14
Medically Unnecessary	<u>105</u>
	128
NON-CLINICAL	
Benefit Interpretation	85
Use of Network	53
Pre-Authorizations	43
Other	<u>17</u>
	198
TOTAL APPEALS	326

Ten of the 326 appeals were withdrawn by HSS members, while 119 of the appeals, or 37%, were overturned, and 197 were upheld. The relatively low overturn rate is reflective of the large number of non-clinical appeals overall that were filed during the period.

GRIEVANCE PROCESSES AVAILABLE TO HSS MEMBERS

HSS members who have a grievance may seek assistance through three separate grievance processes, the Blue Shield Grievance Process, the Health Service System Grievance Process, and the California State of Managed Health Care Grievance Process.

Blue Shield Grievance Process

HSS members who have been denied coverage or have other issues must first notify Blue Shield of their grievance within 180 days of the incident or action and request an initial determination concerning the claim or services that brought the dissatisfaction. If Blue Shield does not resolve the issue to the member's satisfaction, the member may submit a formal grievance to Blue Shield who will acknowledge receipt of a grievance to the grievant within 5 calendar days with resolution within 30 days.

When the routine grievance process may seriously jeopardize the life or health of a member or when the member is experiencing severe pain, they may go through the Blue Shield's "Expedited" grievance process. In this case, Blue Shield will make a decision and notify the member and Physician as soon as possible but no later than 72 hours following the request.

The HSS Grievance Process

Members have the right to appeal a Blue Shield decision on their grievance with the Health Service System by submitting the facts in writing to the Health Service System within 60 days of the Blue Shield decision. The Health Service System reviews each appeal carefully and where appropriate will work with the vendor on the members' behalf to resolve the issue. Once made, Health Service System notifies the member of its decision.

If the member is dissatisfied with the Health Service System's decision they have the additional right to appeal in writing to the Health Service Board. Members must appeal to the Health Service Board within 10 days and specifically state the basis for disagreement with the decision of the Health Service System. An extension of time may be granted upon the showing of good cause. The Health Service Board will hear all appeals in closed session unless the member requests that it be held in open session. The Health Service Board will grant or deny all appeals submitted. The action taken by the Health Service Board is final.

The Health Service System provides continuous oversight of our contracted vendors, including Blue Shield, through the application of performance guarantees, annual vendor reports, and the member grievance process. This has contributed to the low rate of appeals. To enhance this oversight, beginning with the next fiscal year, Health Service System will be incorporating a requirement for quarterly reporting on grievances, including denials, which we will review with our vendors on a regular basis.

The California Department of Managed Health Care Grievance Process

The California Department of Managed Health Care is responsible for regulating health care service plans. Members may request that this agency review cases where coverage was denied because the service was Medically Necessary or Experimental/Investigational. Members may also contact the Department of Managed Health Care when they need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by Blue Shield, or a grievance that has remained unresolved for more than 30 days.

If a member has a grievance against Blue Shield, and is unsatisfied with the result of the Blue Shield grievance process, they can contact the Department of Managed Health Care to request a Review. If the member is eligible they will receive an impartial review of medical decisions made by Blue Shield related to the Medical Necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The member may submit additional records to the review agency to include in the review. Once an opinion has been made the member and his/her physician will receive copies of the opinion. The decision resulting from the State review is binding on Blue Shield. If found to be Medically Necessary, Blue Shield will promptly arrange for the service to be provided. If the claim involves a financial dispute, reviews that are decided in the member's favor must promptly be paid by the HMO.

CONCLUSION

The Health Service System is dedicated to serving as an advocate for our members as they navigate the healthcare system. An important aspect of that is the department's commitment to making Health Service System members aware of all the avenues available to them for contesting the decisions of our contracted medical plan vendors.