

Member Appeals and Grievances

Providers/practitioners may appeal a denied benefit certification formerly (prior authorization) or a concurrent review decision to deny authorization that was made by the Medical Director, with written consent from the member to act as their representative during the appeal process. At the time of the decision, a provider/practitioner or member may request that Presbyterian reconsider the denial by submitting further documentation to support medical necessity. Such requests will be referred to a Medical Director not previously involved in the case for resolution and will be handled according to the Member Appeal guidelines.

If benefit certification for services for any Presbyterian member is requested by a provider/practitioner and denied by Presbyterian, a provider/practitioner may act on the member's behalf and may file a request for an expedited appeal if the provider/practitioner feels that the member's health and/or welfare are in immediate jeopardy. Presbyterian will then determine if it meets expedited criteria. If the case is deemed expedited, Presbyterian will process the expedited appeal within 72 hours of receipt (time extensions may apply).

The Presbyterian Member Appeals and Grievance process is published in the member's Group Subscriber Agreement (GSA), Summary Plan Description (SPD), Evidence of Coverage (EOC), the Presbyterian Salud Member Handbook, and the Presbyterian Senior Care Evidence of Coverage and Disclosure Information/Member Handbook.

Presbyterian provides a process that ensures all members have the right to exercise their right to an appeal and that they receive the decision within the appropriate and proper time frames for resolution of their appeals. The process applies to the following product lines:

- New Mexico Commercial and Administrative Services Only (ASO) contracts
- Presbyterian Salud (New Mexico Medicaid Managed Care)
- Presbyterian Senior Care (Medicare Advantage)
- Presbyterian Medicare PPO (Medicare Advantage)
- Presbyterian SCI (State Coverage Insurance)

Any member also has the right to file a grievance if he/she is dissatisfied with the services rendered through Presbyterian. In respect to grievances, the member is defined as any individual enrolled in Presbyterian or their designated representative. A provider/practitioner may represent a member in a grievance or appeal with written consent from the member. Member grievances may include, but are not limited to: dissatisfaction with providers/practitioners, appropriateness of services rendered, timeliness of services rendered, availability of services, delivery of services, disenrollment or any other performance that is considered unsatisfactory. The member should submit their grievance or appeal to the Presbyterian Grievance and Appeals Coordinator within the following timeframe:

Grievances/Appeals	Time Frame
<p>Grievances/Appeals challenging an adverse action, decision or policy other than a claim denial:</p> <p>Presbyterian Salud (New Mexico Medicaid Managed Care), and Presbyterian SCI (State Coverage Insurance)</p> <p>Presbyterian Senior Care (Medicare Advantage) and Presbyterian Medicare PPO (Medicare Advantage)</p> <p>All Other Plans</p>	<p>Within 90 days from the date of denial</p> <p>Within 60 days from the date of denial</p> <p>Within 180 days from the date of denial</p>