# Right to an appeal

## Standard appeals

Members who receive a denial, reduction, or limitation notice for services may initiate an appeal within the specified time period as described in their notice of non-coverage or explanation of benefits. We resolve most non-Medicare Advantage standard appeals within 14 to 30 days. Medicare Advantage, Part C, standard pre-service reconsideration requests are decided within 30 days and post-service requests within 60 days. Medicare Advantage Part D standard pre-service redetermination requests are processed within 7 days and post-service requests within 14. Medicare Advantage Part B standard pre-service redetermination requests are processed within 7 days and post-service requests within 60.

Standard Medicare Advantage appeals must be in writing. Standard non-Medicare Advantage appeals can be submitted orally or in writing.

You may supply supporting statements and records in a member's appeal.

For standard Medicare Advantage and non-Medicare Advantage post-service appeals, with the member's permission, you may file an appeal on their behalf with AOR.

For standard pre-service Medicare Advantage appeals, with member’s permission, you may file an appeal on their behalf without AOR.

For standard pre-service non-Medicare Advantage appeals, with the member’s permission, you may file an appeal on their behalf with AOR.

## Expedited appeals

If a member's life, health, or ability to regain maximum function would be jeopardized by following the standard appeal process, you may request an expedited appeal on their behalf without AOR. You must make your request to Kaiser Permanente orally or in writing before the member receives the services in question.

Appeals criteria and time frames for resolution are identical for all members requesting an expedited appeal. Since our response time is 72 hours or less, please provide medical records to support the appeal within 24 hours or less of the request, using fax, courier, or other appropriate means.

We respond to Medicare Advantage and non-Medicare Advantage expedited appeals within 72 hours from their receipt. However, some non-Medicare Advantage contracts specify different time frames and appeal processes.

We handle requests that do not meet the expedited appeal criteria according to our standard 7-60 day redetermination/reconsideration (appeal) processes.

## Subsequent appeal levels

Subsequent appeal levels vary, depending on the member's health plan group. Medicare Appeals that are upheld are automatically sent for an external review. Commercial appeals that are upheld are sent for external review at the request of the member and must be made within 180 days. These processes are described in detail in the appeal attachments sent with the denial or appeal letters.