Section 23

Member Appeals

Contents

Member Appeal/Grievance Procedures – Overview

The Blue Cross® Blue Shield® of Arizona (AZ Blue) member dispute process covers commercial member appeals and member grievances in accordance with applicable law, as defined below.

Notes: For Medicare Advantage member appeals and grievances, see page 23-6. For other exceptions, see page 23-3.

Definitions

Member appeal
A member appeal is an oral or written request by a member, a provider acting on behalf of a member, or a member's authorized representative to challenge an adverse determination made by AZ Blue [1] to deny or partially deny a request for prior authorization, continuation of an inpatient stay or course of treatment, or a claim for services already provided.

Appeals are filed to challenge how AZ Blue applied clinical criteria to determine medical necessity of a covered service, including denials or restrictions based on appropriateness (i.e., healthcare setting, level of care or effectiveness), or whether the service is considered experimental or investigational.

Member grievance
A member grievance is a dispute about how AZ Blue applied the member cost share, such as copayment, deductible, coinsurance, and level of benefits.

When to use the member appeal process

The member appeal process is used for disputes related to an adverse determination. A determination is considered adverse when AZ Blue has:

1. Denied a prior authorization request or a claim.
2. Denied, reduced, rescinded, or terminated coverage for a service (in whole or in part)

A member appeal can be filed when an adverse determination was made because AZ Blue decided that a service was:

- Not medically necessary or appropriate (i.e., based on the healthcare setting, level of care or effectiveness of a covered benefit)
- Experimental or investigational
- Not a covered benefit

When to use the member grievance process

The member grievance process is used for disputes not related to adverse determinations as described above. A member grievance can be filed when AZ Blue makes decisions about other things, such as:

- The amount paid for a service or treatment
- How benefits were coordinated with more than one insurer
- How member cost-share or deductible amounts were applied

[1] In some cases, we may be acting as an administrator for a self-funded group health plan, and not in our capacity as an insurer. In this section, references to AZ Blue include any delegated vendors who may process an appeal on our behalf.

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Authorization to represent

Laws and benefit plans vary regarding a provider's right to initiate an appeal/grievance on behalf of a member. For most AZ Blue plans, the following individuals are authorized to appeal or grieve a decision and do not need any special authorization form:

- The treating provider acting on the member's behalf
- A parent acting on behalf of a minor

Exceptions: A few AZ Blue plans for self-funded groups require specific member authorization before the provider can pursue an appeal for the member. In these cases, a provider who is appealing on a member's behalf should use the Authorized Representative Designation form (available on our Appeals and Grievances page) to send us the patient's authorization allowing the provider to receive appeal information on the patient's behalf.

A provider initiating an appeal on behalf of a member should send the patient a copy of all information shared with us in connection with the appeal or grievance.

Note: Not all states allow providers to automatically initiate an appeal/grievance on behalf of a member.

Documentation to include when supporting an AZ Blue member appeal/grievance

To enable us to timely and accurately respond to an appeal/grievance, providers should include the following information:

- A reference to the action or copy of the decision notice that is being appealed
- A written explanation of why the action may be incorrect, and the relief requested
- Documentation that disputed services meet the clinical criteria or pharmacy coverage guidelines
  - Clinical criteria are available on the AZ Blue provider portal at "Practice Management > Medical Policies" and also on our Medical Policies and Prior Authorization page.
  - Pharmacy coverage guidelines are available at azblue.com/Pharmacy
- All other documentation that supports the appeal, such as medical records, operative reports, and office notes

The provider and member are responsible for sending all relevant information to support a dispute and show why we should change our original determination. We do not solicit records to support an appeal/grievance. If the provider or member does not provide documentation, we will make the determination using only the information we already have.

AZ Blue member appeal/grievance packets

We have a defined appeal/grievance process for members and their treating providers. However, some large, self-funded employer groups have d customized the appeal process for their benefit plans and may have different timelines and other protocols that deviate from the process used for most AZ Blue members.

The specific dispute processes are explained in the member's appeal/grievance packet, which also includes all related forms and time frames. For most member disputes, providers will use one of three main appeal packets available on our Appeals and Grievances page:

1. **AZ Blue Member Appeal/Grievance Packet** (for most commercial group plans and grandfathered and grandmothered individual/family plans)

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2. **ACA Member Appeal/Grievance Packet** (for ACA individual/family plans)

3. **Self-Funded Group Member Appeal/Grievance Packet** (for most self-funded employer group plans, except those that have their own *customized* appeal process)

   Self-funded groups with customized appeal processes:

   - **State of Arizona** (group 30855; member ID prefixes SYD and S3Z)
   - **Teamsters** (groups 31843 and 31844; member ID prefix TYW)
   - **U-Haul** (group 026229; member ID prefix UHL) – see the member benefit book

For help in determining which appeal/grievance packet or process to use for a particular member, call Provider Assistance at 1-844-995-2583.

Expedited appeals for services not yet rendered
Expedited appeals require the treating provider to certify in writing that using the time periods for standard appeals could seriously jeopardize the member's life, health, or ability to regain maximum function, cause a significant negative change in the member's medical condition at issue, or subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

The expedited appeal form (Provider Certification Form for Expedited Appeal) is available for download on our Appeals and Grievances page.

Costs
Members and treating providers are not responsible for the cost of the member appeal/grievance dispute process or the cost for an external independent review.

Exceptions to the standard appeal/grievance dispute processes and time frames
The AZ Blue standard member appeal/grievance dispute processes and time frames *do not* apply to:

- BlueCard members from **other Blue Plans,** which have their own member appeal procedures and time frames (some Plans have a 180-day window for submitting an appeal).
- Members with a **self-funded group plan** that customizes its member appeal procedures (some use a 180-day time frame for submitting appeals).
- Enrollees in the **Federal Employee Program® (FEP®)** – Providers cannot appeal an FEP claim denial unless they are appealing on the member's behalf *with signed consent from the member*. For details, refer to the member brochures at fepblue.org. For provider disputes regarding adverse benefit determinations, refer to the provider dispute resolution processes in Section 22.
- Members with **AZ Blue Medicare Advantage (MA) plans** – For information about MA member appeals/grievances, see page 23-6.
- **Provider grievances** – Refer to the provider dispute resolution process in Section 22 related to provider grievances.

We delegate responsibility for member appeals of some benefits to other vendors. Those vendors are also identified in the standard appeal/grievance packets on our Appeals and Grievances page. (See next page for additional contact information for member dispute submissions.)

Member Appeal/Grievance Procedures – Overview

Written notice

- When we decide not to authorize or approve a service not yet provided, we send a written notice to the member and the treating provider. The notice informs the member of the right to appeal the decision and explains the steps of the appeal process, including the right to request an external independent review.
- When we do not pay for a claim for a service already provided, we send a notice to the member and the in-network treating provider. The notice informs the member of the right to appeal the decision and explains the steps of the appeal process, including the right to request an external independent review.
- Before we make a final adverse determination that relies on new or additional evidence, we will send the new or additional evidence to the member.
- Additionally, we send the member and the treating provider our written determination on an appeal. The written determination explains the criteria used, clinical reasons, references to supporting documentation, and the basis and rationale for the decision. It also includes a statement of any additional appeal rights that may be available.

Contact information for submitting member appeals/grievances

Except as otherwise indicated below, send all member appeals/grievances to:

AZ Blue Medical Appeals and Grievances Department – Mailstop A116
P.O. Box 13466
Phoenix, AZ 85002-3466

Phone: 602-544-4938 or 1-866-595-5998

Fax: 602-544-5601

Exceptions to the above contact information:

- **For members with the ACA StandardHealth with Health Choice plan,** send member appeals/grievances to:

  BCBSAZ Health Choice
  Attn: HC Member Grievances
  8220 N. 23rd Ave
  Phoenix, AZ 85021

- **For members with self-funded group plans administered by a third-party administrator (TPA),** the group's TPA is responsible for handling all member appeals/grievances. Send member appeals/grievances to the TPA as instructed on the remittance advice.

- **For FEP members,** refer to the benefit plan brochures at fepblue.org. For provider disputes regarding adverse benefit determinations, refer to the provider dispute resolution processes in Section 22.

- **For BlueCard (out-of-area) members** (other Blue Plans have their own dispute procedures), send all BlueCard appeals and grievances directly to AZ Blue.

  Note: We process disputes related to claim coding and pricing and forward all other appeals to the member's home Blue Plan for resolution.

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Send BlueCard member appeals and grievances to:

BlueCard Host Claims – Mail Stop T201
AZ Blue
P.O. Box 13466
Phoenix, AZ 85002

Fax: 602-864-5120

- **For Medicare Advantage members,** see contact information on page 23-6.

- **For chiropractic services administered by American Specialty Health (ASH):**

  American Specialty Health (ASH)
  Attn: Appeals Coordinator
  P.O. Box 509140
  San Diego, CA 92150

  Phone: 1-800-972-4226

  Fax: 1-877-248-2746

ASH is a separate, independent company, contracted with AZ Blue to provide the chiropractic network, covered chiropractic services, and related claim processing and appeal/grievance resolution.

Medicare Advantage Member Appeal/Grievance Procedures

An AZ Blue Medicare Advantage (MA) member may file a grievance or an appeal with AZ Blue in writing or by calling Member Services. A member may appoint any individual, such as a relative, friend, advocate, an attorney, or a healthcare provider to act as his or her representative.

A provider may not charge a member for representation in filing a grievance or appeal. Administrative costs incurred by a representative during the appeals process are not considered reimbursable.

Appointment of an authorized representative

To be appointed as an authorized representative for an MA member, both the member making the appointment and the representative accepting the appointment (including attorneys) must sign, date, and complete a representative form. Members may appoint a representative using the CMS Appointment of Representative form (CMS-1696), available from the CMS Forms List. Alternatively, a legal representative may be authorized by the court or, in accordance with state law, to act on behalf of a member. This type of appointment could include, but is not limited to, a court-appointed guardian, or an individual who has durable power of attorney for the member.

A signed Appointment of Representative form or other proof of legal representative status is required when a representative files a grievance or appeal on behalf of an AZ Blue MA member. Per CMS guidance, a signed appointment form is valid for the grievance or appeal at hand for up to one year from the date the form is signed by both the member and the representative, unless the member indicates a shorter time frame, or revokes the appointment.

When an appointment of representative document is required, AZ Blue will not begin a grievance or appeal review until or unless all appropriate documents are received. The time frame for processing a grievance or appeal request begins when we receive the appropriate documentation. If we don't receive the appointment documentation or other requested documentation within a reasonable period of time, the grievance or appeal will be dismissed on the grounds that a valid request was not received.

1. MA MEMBER GRIEVANCES (complaints)

A member (or authorized representative) may file a grievance to convey the member's dissatisfaction with AZ Blue or a contracted provider, regardless of whether remedial actions are possible.

Grievances may include concerns about:

- Operational issues such as long wait times, difficulty getting through to the health plan or a provider on the phone
- Benefits package
- Access to care
- Customer service
- Quality of care
- Interpersonal aspects of care (e.g., the demeanor of healthcare personnel or rudeness or disrespect to members)
- Adequacy of facilities

Filing an MA member grievance

An MA member (or authorized representative) may file a grievance orally or in writing within 60 calendar days after the date the event occurred.

Medicare Advantage Member Appeal/Grievance Procedures

A grievance must include a complete description of the issue along with details such as date and time of the event causing the member's dissatisfaction, the location of the event, the name(s) of the people (e.g., service provider, employee, or agent) who were involved in or witnessed the event, and what circumstances caused the dissatisfaction (e.g., concerns regarding access to services, the quality of care, benefit package, aspects of health plan or provider operations or staff).

A member (or authorized representative) can call or send a written grievance to the AZ Blue MA Grievance and Appeals Department at:

P.O. Box 29234
Phoenix, AZ 85038-9234

Phone: 1-800-446-8331 (TTY 711)
Fax: 602-544-5656

MA member grievance review process
The MA Grievance and Appeals Department conducts an investigation concerning the member's grievance. During this process, we will contact any providers or departments related to the member's grievance, address the grievance as quickly as possible, and respond to the member (or authorized representative) verbally or in writing no later than 30 calendar days after receiving the grievance.

We may extend the timeframe by up to 14 calendar days if the member requests an extension or if we justify a need for additional time and the delay is in the member's best interest.

If the member has filed an expedited grievance (based on CMS criteria), we will respond to the member (or authorized representative) within 24 hours.

Providers must comply with AZ Blue investigation efforts in a timely manner so that the CMS timelines for processing member grievances can be met.

2. MA MEMBER APPEALS (requests for reconsideration)

A member (or authorized representative) has the right to file an appeal to request reconsideration of an adverse decision made by AZ Blue. Appeals may be filed about:

- A decision to deny or delay in providing, arranging for, or approving healthcare services
- A disagreement about the cost-share amount assigned by the Plan to the member

Member appeal procedures include reconsideration/redetermination by AZ Blue and may also include, under certain escalated circumstances, reconsideration by an independent review entity (IRE), a hearing before administrative law judges (ALJs), review by the Medicare Appeals Council, and a judicial review.

Filing an MA member appeal
According to CMS guidance, an MA member (or authorized representative) may file an appeal orally or in writing within 60 calendar days from the date of a denial notice. If the appeal is filed beyond the 60 calendar-day time frame and good cause is not provided, we will dismiss the case. All member appeals (requests for reconsideration/redetermination) are acknowledged in writing to the member and the authorized representative; or directly to the legal representative.

An appeal should include an explanation of why the original decision should be reconsidered, along with relevant documents, such as a copy of the adverse organization determination (denial), medical records, and any other documentation that support the appeal.

Medicare Advantage Member Appeal/Grievance Procedures

A member (or authorized representative) can call or send a written request for appeal/reconsideration to the AZ Blue MA Grievance and Appeals Department at:

P.O. Box 29234
Phoenix, AZ 85038-9234

Phone: 1-800-446-8331 (TTY 711)

Fax (Pre-service Part C & D Appeals): 602-544-5655

Fax (Standard Part C Claim Appeals): 602-544-5656

Fax (Standard Part D Claim Appeals): 602-544-5657

Typical review process for MA member Part C appeals
AZ Blue has 30 calendar days to process a standard appeal for medical services that have not yet been provided, and 60 calendar days to process an appeal for reimbursement/payment for services that have already been provided. As part of this process, we will make every effort to obtain all necessary medical records and other information before making a decision. The member (or authorized representative) will be notified in writing of the decision and any additional rights available within the allowed time frame.

If the member, the member's representative, or a treating provider requests an expedited appeal for medical services not yet provided, we will make a decision within 72 hours of the request. In certain situations, if it is in the member's best interest, an extension of up to 14 days may be taken. The member (or authorized representative) will be notified orally of the decision, followed by a written notice within three calendar days of the oral notice.

If the expedited appeal request does not meet criteria to be processed as expedited, it will be changed to a standard appeal time frame. The member (or authorized representative) will be notified in writing of this change and of the right to file an expedited grievance about the decision.

Review process for standard MA pre-service appeals related to Part D prescription drugs
AZ Blue has seven calendar days to process a request for a standard pre-service redetermination regarding Part B and D prescription drugs. During this process, we will make every effort to obtain all necessary records and other information before making a decision. The member (or authorized representative) will be notified in writing of the decision and any additional appeal rights within the allowed time frame.

If AZ Blue approves a request to expedite a redetermination of a Part D prescription drug, a decision will be made within 72 hours of the request. The member (or authorized representative) will be notified in writing of the final decision.

If a request to expedite a redetermination does not indicate that the member's life, health, or ability to regain maximum function could be jeopardized, we may transfer the request to the standard redetermination process. The member (or authorized representative) will be notified in writing within three calendar days of the decision to apply the standard redetermination process and the right to file an expedited grievance about the decision.