Guidelines and Procedures for Members Who Want to Appeal or Grieve an Adverse Benefit Determination

BlueCross BlueShield of Arizona

What is an adverse benefit determination?

An adverse benefit determination occurs when BCBSAZ, as administrator for your group health benefit plan ("plan"), makes any of the following decisions:

- Denies your request for precertification of a service you haven't yet received;
- Denies, reduces, or terminates your plan benefits;
- Fails to provide or pay for a benefit covered under your plan;
- Finds you ineligible for a benefit under your plan;
- Finds you responsible for payment of cost share (copay, deductible, coinsurance, access fee, balance bill) for a plan benefit;
- Finds that a service is not medically necessary;
- Finds that a service is not covered because it is experimental or investigational;
- Determines that you are not eligible for coverage under the benefit plan; or
- Rescinds your coverage under the plan.

How will I know when you make one of these decisions?

We will send you written notice in the form of an "Explanation of Benefits" (EOB) document, a monthly member health statement or a letter. All of these documents will include information about your right to appeal or grieve the decision.

I disagree with how you processed my claim. What do I need to do?

Call us at the number listed on the back of your ID card to explain your situation. Keep in mind, we have to follow the terms of your plan. We can't change the scope of your coverage or rewrite your cost share obligations. But, if we've made a real mistake in how we administered your benefits, we want to fix it.

What if I still disagree with your decision after speaking with a representative?

You always have the right to file an appeal or grievance, free of charge. Information regarding where to file an appeal or grievance will be included on your Explanation of Benefits statement (EOB), your monthly health statement, or a denial letter. Additional contact information is listed in your benefit plan booklet. These resources will identify if BCBSAZ or a vendor made the precertification decision or processed your claim. Whoever makes the decision or processes the claim usually handles your appeal or grievance as well.

The process available to you, and the steps in that process, will vary, based on:

- Whether you are challenging a denial of an urgently needed service that you haven't yet received
- The type of decision you disagree with:
  - If we denied a claim or a precertification request for a service, you have 180 days from the date of denial to request an appeal. (Refer to page 3)
  - If you disagree with how we paid the claim (i.e., copay, deductible, coinsurance, level of benefits, etc.), you have 180 days from the date of the notice to file a grievance. (When your dispute is about how we applied cost share, we call it a "grievance". (Refer to page 5)
- Whether you or your provider bears financial responsibility for the decision (BCBSAZ contracted providers are sometimes required to write off charges for certain services excluded from coverage under your benefit plan.)

You denied precertification for a service that I need right away. What do I do?

We have an expedited appeal process for members who urgently need a service that has not yet been provided. A service is urgently needed when the time period for a standard appeal could seriously jeopardize a member's life, health, or ability to regain maximum function, or subject the member to severe pain that cannot be managed without the requested service. If you have not yet received a service, and your treating provider certifies that your condition qualifies as urgent, BCBSAZ will treat the appeal as urgent.

Is there anyone who can help me with my appeal?

BCBSAZ customer service representatives can answer questions about the appeal process and help you with filing an appeal. The BCBSAZ customer service number is (844-899-4074). You can also contact the U.S. Department of Labor – Employee Benefits Security Administration at 1-866-444-EBSA (3272).

At the end of this brochure are forms that you may use for your appeal. You are not required to use these forms.

What are the processes for appeals and grievances?

The following charts show the processes for both expedited and standard appeals and for grievances.

APPEAL PROCESS FOR PRECERTIFICATION AND CLAIM DENIALS, AND RESCISSION OF COVERAGE

(For payment disputes see Member Grievances page 5)

<table>
<tr><th colspan="3">Internal review by BCBSAZ (or BCBSAZ Contracted Vendor [1])</th></tr>
<tr><th>Level 1 – Initial</th><th>Expedited Appeals</th><th>Standard Appeals</th></tr>
<tr><td>If you disagree with a BCBSAZ decision, how long do you have to file an appeal?</td><td>Up to 180 days from the date of the decision from which you disagree, but if you wait a long time after we deny precertification for a requested service, it usually means that the appeal does not require expediting, and can follow the standard process.</td><td>Up to 180 days from the date of the decision with which you disagree.</td></tr>
<tr><td rowspan="2">What do you need to send for an appeal?</td><td colspan="2">You and your provider must send the appeal request and any other information you want us to consider in writing. Verbal requests may only be made for expedited or pre-service appeals. Make sure to include at least the following information in your appeal request:
• The decision or action you disagree with,
• Why you think our original decision is wrong,
• What you are asking BCBSAZ to do differently, and
• Any medical records that support your request
No special form is required. At the end of this brochure is an optional appeal form that you can use.</td></tr>
<tr><td>Your provider will also need to certify that the appeal involves an urgent medical situation. At the end of this brochure is a certification form that your provider can use, but is not required to use.</td><td></td></tr>
<tr><td>Where do you send your appeal?</td><td colspan="2">Refer to the Explanation of Benefits statement (EOB), monthly health statement or precertification denial letter you received for information on filing your appeal. Information specific to your plan is also listed in your benefit plan booklet.</td></tr>
<tr><td>Who will review your case?</td><td colspan="2">Someone who was not involved in making the decision you are appealing, and who is not compensated, rewarded or promoted for upholding the original decision. For issues involving medical judgment, the review will include consultation with a health care professional who has appropriate training and experience in the field of medicine involved.</td></tr>
<tr><td>How long does BCBSAZ[1] have to notify you of its decision?</td><td>Within 72 hours from the time of your request. BCBSAZ will notify you by phone and by mail.</td><td>BCBSAZ will acknowledge receipt of your appeal within 5 business days and send you a written decision within 15 days for pre-service appeals and within 30 days for post-service appeals.</td></tr>
<tr><td>What can you do if you still disagree with the decision?</td><td colspan="2">For Pre-service Requests: You may be eligible for an external independent review if the adverse benefit determination is based on medical judgement. Cases based on “medical judgement” are those involving plan requirements for medical necessity, medical appropriateness, health care setting, level of care, benefit effectiveness, or a determination that a treatment is investigational or experimental.

For Post-service Requests: You can request another level of review from the Board of Trustees. This information is included in your appeal decision letter. After the Board of Trustees’ review, you may be eligible for an external independent review if the adverse benefit determination is based on medical judgement. Cases based on “medical judgement” are those involving plan requirements for medical necessity, medical appropriateness, health care setting, level of care, benefit effectiveness, or a determination that a treatment is investigational or experimental.</td></tr>
</table>

[1] Remember to check your benefit plan booklet, your EOB or monthly health statement, or your denial letter to determine if a vendor administers the type of benefit at issue. For ease of reference, we have used the term “BCBSAZ” in these charts when describing actions that the plan has to take. In some cases, a vendor may handle the appeal.

APPEAL PROCESS FOR PRECERTIFICATION AND CLAIM DENIALS, AND RESCISSION OF COVERAGE

Requesting External Independent Review		
How long do you have to request external independent review?	You must file a written request within 4 months of the date of the final internal review decision. If you want your appeal to be expedited, there is no required shorter time period, but if you wait a long time after the decision, it usually means that the appeal does not require expediting, and can follow the standard process	
Type of Appeal	**Expedited Appeals**	**Standard Appeals**
How long does BCBSAZ have to review your request for external review?	Within 1 business day BCBSAZ must determine if your request is eligible for external review, and you have submitted all the information needed to send the case to an external reviewer. Within that period, BCBSAZ will notify you if your case is not eligible for external review or your submission is incomplete.	BCBSAZ has 5 business days to review your request to make sure it is eligible for external review, and to determine whether you have submitted all the information needed to send the case to an external reviewer. BCBSAZ then has 1 additional business day to notify you if your case is not eligible for external review or your submission is incomplete.
If your submission is incomplete, how long do you have to send the missing information?	You can send the information any time before the end of the initial 4-month period, or if that time has expired, you have 48 hours after you receive BCBSAZ's notice of incomplete submission to send the missing information.	
If your case is eligible for external review, who will review it?	BCBSAZ refers all appeals related to medical necessity, investigational services, and medical question cases to an External Independent Review Organization ("IRO").	

External Independent Review		
Appeals Submitted to IRO	**Expedited Appeals**	**Standard Appeals**
Submission of additional information	The IRO notifies you that it has accepted your case. You have up to 10 business days to provide the IRO with more information that you want the IRO to consider.	
Other time periods	If you provide the IRO with new information, the IRO has 1 business day to send it to BCBSAZ. Based on the new information, BCBSAZ may decide to change its internal decision, and would notify you and the IRO of this change.	
Time period for IRO to issue a decision.	The IRO must issue a decision as quickly as possible in light of the medical circumstances, but no later than 72 hours after receiving the request for external review. If the IRO's decision is not issued in writing, the IRO has another 48 hours to provide written confirmation of the decision.	The IRO must issue a decision within 45 days after receiving the request for external review.
What happens after the IRO's decision?	If the IRO upholds the decision, you may have other legal recourse to challenge the decision in court. If the IRO reverses or modifies the decision in your favor, BCBSAZ must comply with the IRO's decision.	

MEMBER GRIEVANCE

Process to Dispute Decisions about Member Cost Share

(For denial of a precertification or claim see Appeals page 3)

Step	Response Period
Level 1 – Initial	
Time period you have to file your grievance	Up to 180 days from the date of the decision with which you disagree.
Time period for BCBSAZ to notify you of its decision	Pre-service issues: Within fifteen (15) days from the date BCBSAZ receives your grievance request. Post-service claims: Within thirty (30) days from the date BCBSAZ receives your grievance request.
Where do you send your grievance?	Refer to the Explanation of Benefits statement (EOB), monthly health statement or precertification denial letter you received for information on filing your grievance. Information specific to your plan is also listed in your benefit plan booklet.
What can you do if you still disagree with BCBSAZ's decision?	For post-service issues you can request a second level of review from the Board of Trustees. This information will be included in your decision letter.

Can I have someone else file the appeal or grievance for me?

You can authorize someone else to file an appeal or grievance on your behalf, including your treating provider. The individual you designate will be your "authorized representative." Once you designate someone as your authorized representative, that person has the right to make decisions about your case (for example, whether to seek review at a higher level, if available.) Also, BCBSAZ will send information about the progress of your case to the representative, with a copy to you.

If your pre-service appeal is urgent, your treating provider may act on your behalf without a special authorization.

If a special authorization is required, we will let you know and make sure you have time to get the authorization. Also, the following individuals may appeal or grieve a decision for you, if you send BCBSAZ the required proof of authority:

Designated representative	Required proof of authority
Member's legal guardian	Official copy of the court order appointing the guardian
Your agent	Power of attorney authorizing the agent to appeal or grieve a healthcare decision; or Health care power of attorney that authorizes the agent to make health care treatment decisions for you.
Your surrogate	Someone who qualifies as a surrogate and includes a written confirmation from a treating provider that the member is unable to make or communicate health care treatment decisions
Executor or personal representative	Official copies of the death certificate and court order appointing the executor or personal representative
Court appointed representative (adult authorized by any other type of court order to make health care decisions for a member)	Official copy of the court order

I already signed a privacy release form. Why do I have to sign another form to have someone represent me?

You cannot use a Confidential Information Release Form (CIRF) to designate an authorized representative. A CIRF allows us to send your protected health information to someone else, but it is not proof of their authority to act on your behalf.

If BCBSAZ receives an appeal or grievance request from a third party who claims to be your authorized representative, including those situations shown above, BCBSAZ may require you to confirm directly to us in writing the scope of any authority the third party may have. In that case, we will not recognize the third party's authority until we receive your confirmation.

How can I get medical records to send them to you?

You can ask for a copy of your medical records. Your request must be in writing and must specify who you want to receive the records. The health care provider who has your records will provide you or your authorized representative with a copy of your records. If you have to obtain medical records from your provider, your provider has the right to charge for copies of records, so you may have to pay for those copies.

If you have a designated health care decision-maker, that person must send a written request for access to copies of your medical records. The medical records must be provided to your health care decision-maker or a person designated in writing by your health care decision-maker, unless you limit access to your medical records only to yourself or your health care decision-maker.

I am worried about sharing my medical information with so many people. Will my records be kept confidential?

If you participate in the appeal or grievance process, the relevant portions of your medical records may be disclosed only to people authorized to participate in the review process for the medical condition under review. These people may not disclose your medical information to others.

If I still disagree with the final decision, is there anything else I can do?

These appeal and grievance rights are in addition to your rights to challenge the decision in court. For many group plans (other than government plans and church plans), court action may include legal action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA). If you are enrolled in an ERISA qualified group plan, you and your plan may have other voluntary alternative dispute resolution options in addition to these Appeals and Grievance Processes described in your benefit plan booklet, such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office. You may also be able to obtain information from your group benefits administrator.

Receipt of Documents

Any written notice, acknowledgment, request, decision or other written document required to be mailed is deemed received by the person to whom the document is properly addressed on the fifth business day after being mailed. "Properly addressed" means your last known address.

Appeal/Grievance Request Form

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You may use this form to tell BCBSAZ you want to appeal or grieve a decision.

Member Name _____ Member ID# _____

Name of representative pursuing appeal, if different from above _____

Mailing Address _____

Phone # _____

City _____ State _____ Zip Code _____

Type of Appeal/Grievance ☐ Denied Claim ☐ Denied Service Not Yet Received ☐ Cost Share Dispute

Claim # (if applicable) _____ Date of Service _____

If you are appealing BCBSAZ's decision to deny a service you have not yet received, could a 15 day delay in receiving the service likely seriously jeopardize your life or health or your ability to regain maximum function, or subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request? If your answer is "Yes," you may be entitled to an expedited appeal. Your treating provider can send us the attached certification and documentation supporting the need for an expedited appeal.

What action or decision are you disputing? _____

Explain why you believe the decision or action was wrong and what you want BCBSAZ to do differently:

_____

_____

_____

(Attach additional sheets of paper, if needed.)

If you have questions about the appeals or grievance process or need help to prepare your request, call BCBSAZ at: 844-899-4074.

Make sure to attach everything that shows why you believe BCBSAZ should process your claim differently or authorize a service, including: ☐ Medical records ☐ Supporting documentation (letter from your doctor, brochures, notes, receipts, etc.) You may also attach the certification from your treating provider if you are seeking expedited review.

Medical Appeals and Grievances Department
BCBSAZ Mail stop A116
P.O. Box 13466
Phoenix, AZ 85002-3466
Fax: (602) 544-5601
Phone: 844-899-4074

Signature of member or authorized representative _____ Date _____

Provider Certification Form for Expedited Appeal

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Is the appeal for a service that the patient has already received? ☐ Yes ☐ No

If "Yes," the patient must pursue the standard appeals process and cannot use the expedited appeals process. If "No," continue with this form.

Provider Information

Treating Physician/Provider _____

Phone # _____ Fax # _____

Address _____

City _____ State _____ Zip Code _____

Patient Information

Member Name _____ Member ID # _____

Phone # _____ Fax # _____

Address _____

City _____ State _____ Zip Code _____

What service denial is the patient appealing? _____

_____

_____

Explain why you believe the patient needs the requested service and why the time for the standard appeal process will harm the patient. _____

_____

_____

Fax this form with any supporting documentation and medical records to

BCBSAZ at **(602) 544-5601**

I certify, as the patient's treating provider, that delaying the patient's requested service for the time periods applicable to the standard appeal process is likely to seriously jeopardize the patient's life, health or ability to regain maximum function or subject the patient to severe pain that cannot be adequately managed without the requested service.

Provider's Signature_____ Date _____

If you have questions about the appeals process or need help to prepare your Appeal, you may call BCBSAZ at 844-899-4074.

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