Understanding: *Claims Appeal – Medical*

For a member of the BlueCross BlueShield health plans (SelectCare POS and TotalChoice) who has a complaint regarding quality of care, benefits, claim or medical necessity denials

Claims Appeal Process

What It Is

An official process established to address complaints of BlueCross BlueSheild (BCBS) health care network participants with three levels for reviewing or appealing any complaints you have regarding quality of care or benefits.

The Committee that reviews your case is an independent committee within the health plan that is responsible for resolving participants' complaints.

Who It's For

Members of the State of Vermont BCBS health plans (SelectCare POS and TotalChoice) who have specific concerns or complaints – regarding quality of care and/or administrative issues – about the BCBS HealthCare network.

Watch Your Step . . .

■ When initiating the appeals process, be sure to keep a detailed record of all conversations you have regarding your complaint, including:

– Full names of everyone with whom you speak

– Dates of any conversations

– Any deadlines that may affect your case

– Any rules or restrictions regarding the appeals procedure that you don't already have in writing.

■ Always specifically ask about any deadlines that may affect the outcome of your case. Then, record the name of the person who gave you the deadline, the date of your conversation and the deadline.

■ Confirm all information you receive by reading your notes back to the person giving you the information.

■ Keep a file of all your correspondence and phone conversations.

The 4 Steps to the Appeal Process: *Medical*

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1

FIRST STEP

Call Member Services using the phone number on the back of your BCBS ID card if you have a complaint or questions regarding the following:

- In-network or out-of network benefits covered under the BCBS plan
- Quality of care received from participating providers
- Claim denials
- Denial of services

2

FIRST LEVEL APPEAL

If you are not satisfied with the response from Member Services to your complaint about a denial determination, you can initiate a

formal appeal by following the steps below:

- Call Member Services and advise the Rep that you want to initiate a formal appeal. You may also obtain the appeal address during this phone call and send in a written appeal
- Explain (either by phone or in writing) why you believe the denial should be reconsidered. Refer to facts that support your opinion and include any relevant medical documentation from your doctor(s)
- Include any additional documentation that you feel will clarify your position

3

SECOND LEVEL APPEAL

If you remain dissatisfied with the response to your first level appeal, you may file a

formal second level appeal through BCBS Health Care by following the steps below:

- Send a letter to BCBS health care as outlined in the response letter received in step 2.
- Restate the reasons you believe the original denial decision should be reversed
- Include all pertinent information and documentation that you feel will substantiate your position. Include any new information not already provided

When the BCBS health care Appeals Coordinator receives your formal appeal:

- An official Appeals Committee will review your case within the appropriate timeframe as outlined below*
- Will give you the option of presenting your case in person or telephonically to the Appeals Committee at a scheduled time. At the hearing, the committee members can ask you questions to clarify your position.

4

FINAL APPEAL

If you are not satisfied with the decision of the internal Grievance Committee you may be eligible for a third level appeal as outlined in the response letter.

***Response Timeframe:** 24 hours for concurrent, 72 Hours for expedited, 30 calendar days for pre-service and 60 calendar days post-services.