Appeal Process

Introduction

As described below, Blue Cross has two different processes to resolve appeals: one for appeals that do not require a medical determination; and, one for appeals that do require a medical determination. With an exception described below, you are required to submit a first level appeal before you can exercise any other rights to appeal or other review. If the decision on that first level review is wholly or partially adverse to you, you may either file a second level appeal within Blue Cross or you may seek review external to Blue Cross. If you choose to file a second level appeal within Blue Cross, and that decision is wholly or partially adverse to you, you can then seek external review. There is an exception for cases that qualify for an expedited appeal. For those cases, you may seek external review at the same time you request an expedited first level appeal.

You can call or write us with your appeal. We will send an appeal form to you upon request. If you need assistance, we will complete the written appeal form and mail it to you for your signature. We will work to resolve your appeal as soon as possible using the appeal process outlined below.

In addition, you may file your appeal with the Minnesota Commissioner of Commerce at any time by calling 651-539-1600 or toll free 1-800-657-3602. If you are covered under a Plan offered by the State Health Plan, a city, county, school district, or Service cooperative, you may also contact the U.S. Department of Health and Human Services Insurance Assistance Team at 888-393-2789.

Definitions

Adverse Benefit Determination means a decision relating to a health care Service or Claim that is partially or wholly adverse to the complainant.

Appeal means any grievance that is not the subject of litigation concerning any aspect of the provision of health Services under this booklet. If the appeal is from an applicant, the appeal must relate to the application. If the appeal is from a former member, the appeal must relate to the provision of health Services during the period of time the appellant was a member. Any appeal that requires a medical determination in its resolution must have the medical determination aspect of the appeal processed under the utilization review process described below.

Appellant means a member, applicant, or former member, or anyone acting on his or her behalf, who submits an appeal.

Member means an individual who is covered by a health benefit Plan.

First Level Appeals That Do Not Require a Medical Determination

First Level Oral Complaint

If you call or appear in person to notify us that you would like to file a complaint, we will try to resolve your oral complaint as quickly as possible. However, if our resolution of your oral complaint is wholly or partially adverse to you, or not resolved to your satisfaction within 10 days of our receipt of your oral complaint, you may submit a first level appeal in writing. We will provide you an appeal form on which you can include all the necessary information to file your written appeal. If you need assistance, we will complete the written appeal form and mail it to you for your signature. You must tell us all reasons and arguments in support of your appeal, and you must identify and provide all evidence in support of your appeal unless that evidence is already in our possession.

First Level Written Appeals

If we decide a Claim that is wholly or partially adverse to you, and you wish to appeal, you are required to submit a first level appeal. You may submit your appeal in writing, or you may request an appeal form on which you can include all the necessary information to file your appeal. Your appeal must state all reasons and arguments in support of the appeal, and you must submit all evidence in support of your appeal unless that evidence is already in our possession. Blue Cross will notify you that we have received your written appeal.

We will inform you of our decision and the reasons for the decision within 30 days of receiving your appeal and all necessary information. If we are unable to make a decision within 30 days due to circumstances outside our control, we may take up to 14 additional days to make a decision. If we take more than 30 days to make a decision, we will inform you of the reasons for the extension. You have the right to review the information that we relied on in the course of the appeal.

First Level Appeals That Require a Medical Determination

When a medical determination is necessary to resolve your appeal, we will process your appeal using these utilization review appeal procedures. Utilization review applies a well-defined process to determine whether health care Services are Medically Necessary and Appropriate and eligible for coverage. Utilization review includes a process to appeal decisions not to cover a health care Service. This utilization review process is found under “Medical Management” in the “Health Care Management” section. If we deny your requested service the denial letter will describe the process for initiating an appeal.

Utilization review applies only when the Service requested is otherwise covered under this health care Plan.

In order to conduct utilization review, we will need specific information. If you or your Attending Health Care Provider do not release necessary information, approval of the requested Service, procedure, or admission to a Facility provider may be denied.

Definitions

Attending Health Care Provider means a health care professional with primary responsibility for the care provided to a sick or injured person.

Concurrent review means utilization review conducted during a member's Hospital stay or course of Treatment.

Determination not to certify means that the Service you or your provider has requested has been found to not be Medically Necessary and Appropriate, appropriate, or efficacious under the terms of this health care Plan.

Prior Authorization means utilization review conducted prior to the delivery of a Service, including an outpatient Service.

Provider means a health care professional or Facility provider licensed, certified or otherwise qualified under state law, in the state in which the Services are rendered, to provide the health Services billed by that provider. Provider also includes pharmacies, medical Supply companies, independent laboratories, and ambulances.

Utilization review means the evaluation of the necessity, appropriateness, and efficacy of the use of health care Services, procedures and facilities, by a person or entity other than the attending Health Care Provider, for the purpose of determining the Medical Necessity and Appropriateness of the Services or admission.

Standard First Level Appeal

You or your Attending Health Care Provider may appeal Blue Cross' initial determination to not certify Services in writing or by telephone. The decision on this first level appeal will be made by a Health Care Provider who did not make the initial determination. We will notify you and your Attending Health Care Provider of our decision within 30 days of receipt of your appeal. If we are unable to make a decision within 30 days due to circumstances outside our control, we may take up to 14 additional days to make a decision. If we take more than 30 days to make a decision, we will inform you of the reasons for the extension. You have the right to review information relied on in making the initial determination.

Expedited First Level Appeal

When Blue Cross' initial determination to not certify a health care Service is made prior to or during an ongoing Service requiring review and the Attending Health Care Provider believes that an expedited appeal is warranted, you and your Attending Health Care Provider may request an expedited appeal. You and your Attending Health Care Provider may appeal the determination over the telephone. Our appeal staff will include the consulting Physician or Health Care Provider if reasonably available. When an expedited appeal is completed, we will notify you and your Attending Health Care Provider of the decision as expeditiously as the member's medical condition requires, but no later than 72 hours from our receipt of the expedited appeal request. If we decline to reverse our initial determination not to certify, you will be notified of your right to submit the appeal to the external review process described below.

Second Level Appeals to Blue Cross Internal Appeals Committee

If our final decision on your first level appeal is wholly or partially adverse to you, you may appeal our final decision through External Review, as described below. Alternatively, you may voluntarily appeal to our internal appeals committee (second level appeal), as described in this section, before seeking External Review. If you appeal to our internal appeals committee, you may either have the appeal decided solely on the written submissions or you may request a hearing in addition to your written submissions. You may receive continued coverage pending the outcome of the appeals process. You may request a form that on which you can include all the information necessary for your appeal. During the course of our review, we will provide you with any new evidence that we consider or rely upon, as well as any new rationale for a decision. If our decision is wholly or partially adverse to you, the notice will advise you of how to submit the decision to External Review as described below. If you request, we will provide you a complete summary of the appeal decision.

The request for a first, and any second, level appeal should include:

- the member's name, identification number and group number
- the actual Service for which coverage was denied
- a copy of the denial letter
- the reason why you or your Attending Health Care Provider believe coverage for the Service should be provided
- any available medical information to support your reasons for reversing the denial
- any other information you believe will be helpful to the decision maker

Blue Cross will notify you that we have received your second level appeal. You may present evidence in the form of written correspondence, including explanations or other information from you, staff persons, administrators, providers, or other persons. If your appeal is decided solely on the written submissions, you may also present testimony by telephone to a Blue Cross Appeal Liaison.

Within 30 days of receiving your second level appeal and all necessary information, we will notify you in writing of our decision and the reasons for the decision. If you request, we will provide you a complete summary of the appeal decision.

If you request a hearing, you or any person you choose may present testimony or other information. We will provide you written notice of our decision and all key findings within 45 days after we receive your written request for a hearing.

External Review

You must exhaust your first level appeals option prior to requesting External Review unless: 1) Blue Cross waives the exhaustion requirement in writing; 2) Blue Cross substantially fails to comply with required procedures; or, 3) you qualified for and applied for an Expedited First Level Appeal of a medical determination and applied for an Expedited External Review at the same time.

If your appeal concerns a complaint decision relative to a health care Service or Claim and you believe Blue Cross' appeal determination is wholly or partially adverse to you, you or anyone you authorize to act on your behalf may submit the appeal to external review. You must request External Review within six (6) months from the date of the adverse determination. External review of your appeal will be conducted by an independent organization under contract with the state of Minnesota. The written request must be submitted to the Minnesota Commissioner of Commerce along with a $25 filing fee. You will not be subject to filing fees totaling more than $75 per policy year. The Commissioner may waive the fee in cases of financial hardship. Blue Cross will refund the fee if our determination is reversed by the external reviewer.

Minnesota Department of Commerce
Attention: Consumer Concerns/Market Assurance Division
85 7th Place East, Suite 280
St. Paul, MN 55101-2198
651-539-1600 or toll free 1-800-657-3602

The external review entity will notify you and Blue Cross that it has received your request for external review. Within 10 business days of receiving notice from the external review entity, you and Blue Cross must provide the external review entity any information to be considered. Both you and Blue Cross will be able to present a statement of facts and arguments. You may be assisted or represented by any person of your choice at your expense. The external review entity will send written notice of its decision to you, Blue Cross, and the Commissioner within 45 days of receiving the request for external review. The external review entity's decision is binding on Blue Cross, but not binding on you.

Expedited External Review

Expedited external review will be provided if you request it after receiving an adverse determination that involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have simultaneously requested an expedited internal appeal. Expedited external review will also be provided after receiving an adverse benefit determination that concerns (i) an admission, availability of care, continued stay, or health care Services for which you received emergency Services but have not yet been discharged from a Facility provider; or, (ii) a medical condition of which the standard external review time would seriously jeopardize your life or health or jeopardize your ability to regain maximum function.

The external review entity must make its expedited determination to uphold or reverse the adverse benefit determination as expeditiously as possible but within no more than 72 hours after receipt of the request for expedited review and notify you and Blue Cross of the determination. If the external review entity's notification is not in writing, the external review entity must provide written confirmation of the determination within 48 hours of the notification.

The appeals and determination processes described above are subject to change if required or permitted by changes in state or federal law governing appeal procedures.