of Tennessee

# Provider Reconsideration and Appeals

# What is a Provider Claim Reconsideration?

- A **claim reconsideration** allows providers dissatisfied with a claims outcome/denial to request an additional review. Reconsiderations must be requested and completed before filing a formal appeal.
- Provider reconsiderations may be requested in reference to numerous topics, including, but not limited to:
  - Corrected claims
  - Coordination of benefits
  - Diagnoses codes
  - Procedure or revenue codes
  - Recoupment disputes

# What is a Provider Claim Reconsideration?

- For adjudicated claims to be reconsidered, provide adequate supporting documentation.
- You may initiate a reconsideration by calling us or using the Provider Reconsideration Form.
- If you still are dissatisfied after a reconsideration, you may file a formal appeal.

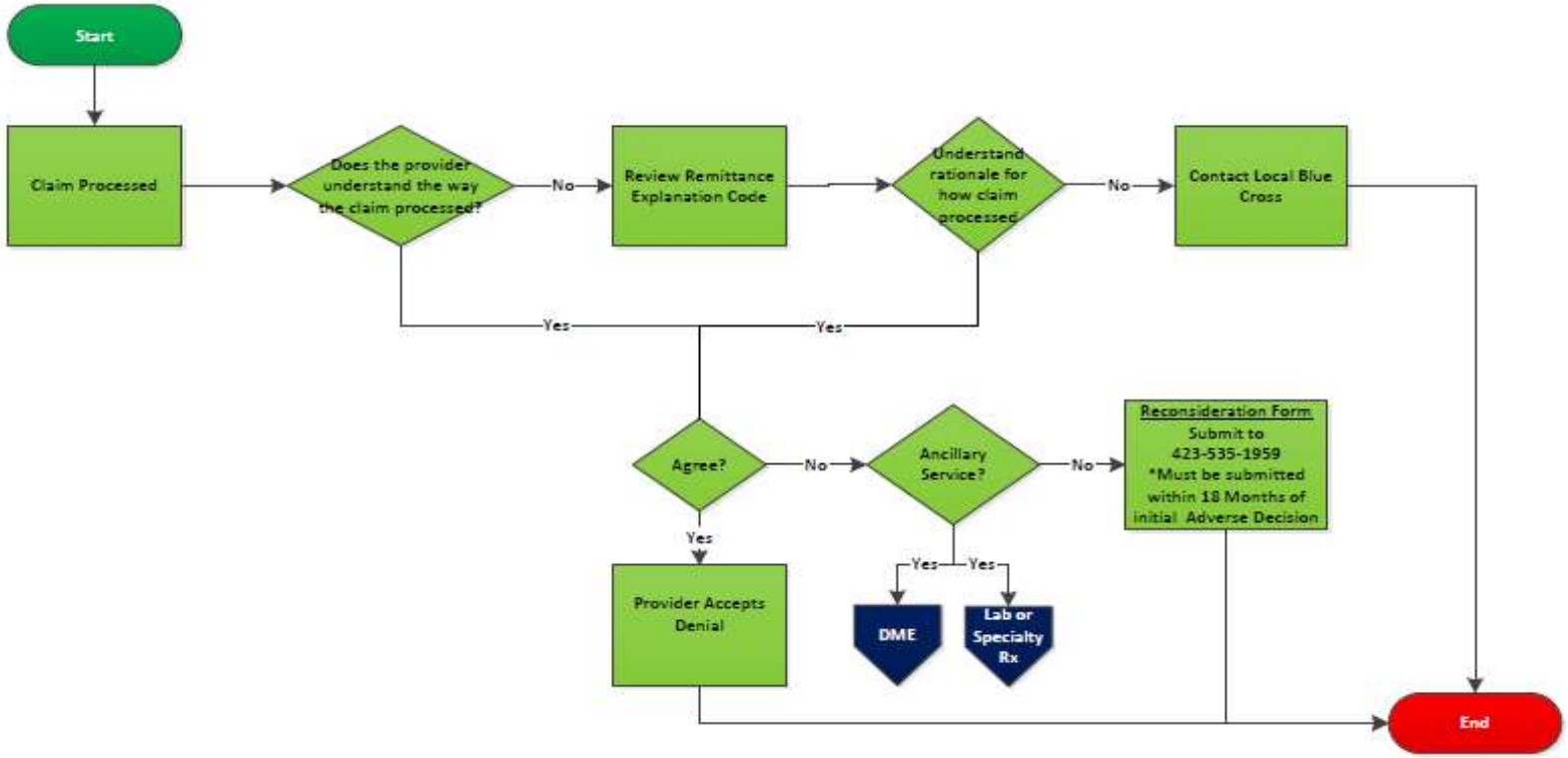
*** NOTE:** ***Authorization reconsiderations/re-evaluations are normally prior to billing and are addressed during the review process and appeals timelines start at time of initial determinations.***

# What Does the Claim Reconsideration Process Look Like?

## Claim Reconsideration

*NOTE:

- Authorization reconsiderations are optional and occur before or during services. This slide addresses *claim* reconsiderations only.
- If, during the claim reconsideration review, it is noted the determination was related to a denied authorization; the timeline for appeal would begin from the initial authorization denial (See timeliness grid).



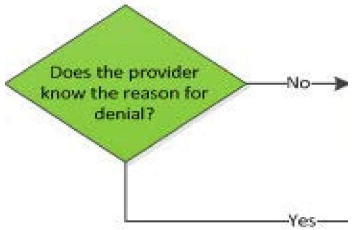
# Claim Reconsiderations:  A Case Study

- The kickoff point for a provider claim reconsideration is a denied claim and a frustrated provider.

- The provider determines his/her reason for reconsidering a claim and begins the process of filing the reconsideration.

# Case Study (continued)

- **Step 1:** Does the provider understand why the claim was initially denied?

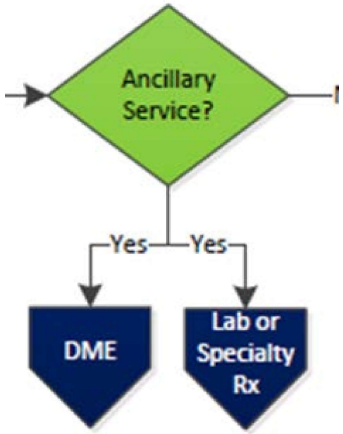



- YES: The provider understands the reason and still disagrees.

- NO: The provider does NOT understand the reason for denial. The remittance code is reviewed, and the provider then determines whether he/she agrees or disagrees with the ruling.

# Case Study (continued)

- **Step 2:** Are ancillary services impacted by the reconsideration?
  - YES: Durable Medical Equipment (DME), Lab and Specialty Prescription claims may only be reconsidered:
    - If DME products were delivered or picked up in Tennessee
    - If Lab or Specialty Rx were ordered by a provider in Tennessee
    - **FEP only:** DME, Lab and Specialty Rx claims may be reconsidered if the provider filing the claim is in Tennessee
  - NO: Providers must complete and fax a reconsideration form to (423) 535-1959 within 18 months of initial denial.

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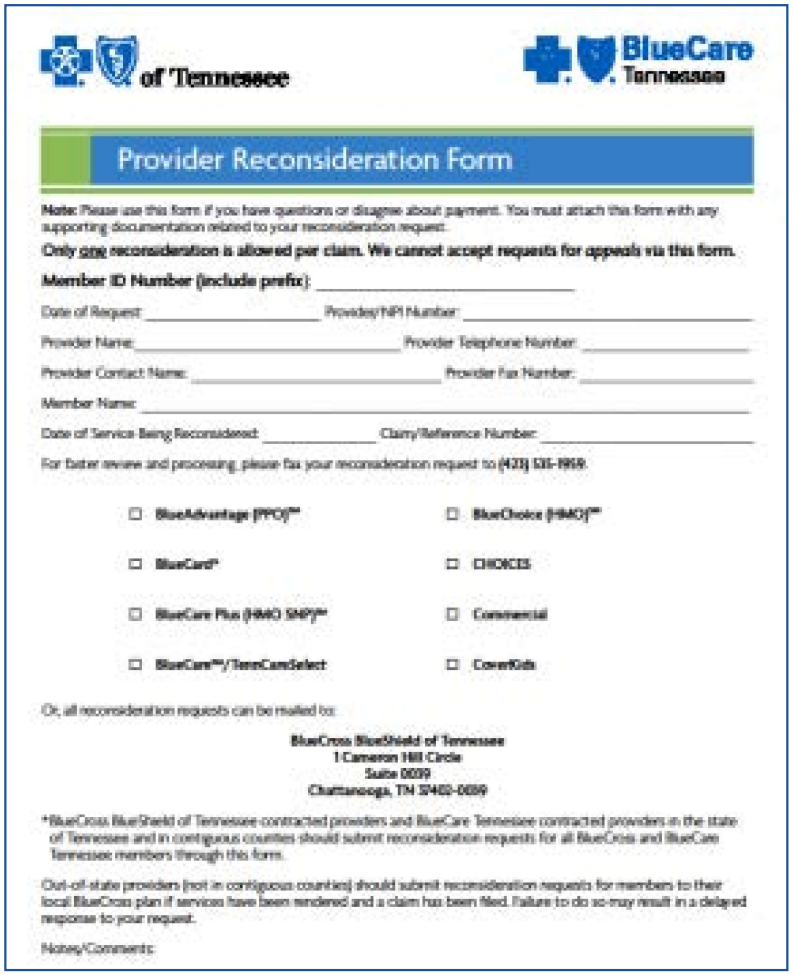
# Submitting a Reconsideration

- **Step 3:** Submit the reconsideration form within 18 months of the initial claims denial.



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## Provider Reconsideration Form

**Note:** Please use this form if you have questions or disagree about payment. You must attach this form with any supporting documentation related to your reconsideration request.

**Only one reconsideration is allowed per claim. We cannot accept requests for appeals via this form.**

**Member ID Number (include prefix):** _____

Date of Request: _____ Provider/NPI Number: _____

Provider Name: _____ Provider Telephone Number: _____

Provider Contact Name: _____ Provider Fax Number: _____

Member Name: _____

Date of Service Being Reconsidered: _____ Claim/Reference Number: _____

For faster review and processing, please fax your reconsideration request to **(423) 535-1959**.

- ☐ **BlueAdvantage (PPO)****
- ☐ **BlueChoice (HMO)****
- ☐ **BlueCard®**
- ☐ **FEHBDS**
- ☐ **BlueCare Plus (HMO SNP)****
- ☐ **Commercial**
- ☐ **BlueCare**/TennCareSelect**
- ☐ **CoverKids**

Or, all reconsideration requests can be mailed to:

**BlueCross BlueShield of Tennessee**
**1 Cameron Hill Circle**
**Suite 0039**
**Chattanooga, TN 37402-0039**

*BlueCross BlueShield of Tennessee contracted providers and BlueCare Tennessee contracted providers in the state of Tennessee and in contiguous counties should submit reconsideration requests for all BlueCross and BlueCare Tennessee members through this form.

Out-of-state providers (not in contiguous counties) should submit reconsideration requests for members to their local BlueCross plan if services have been rendered and a claim has been filed. Failure to do so may result in a delayed response to your request.

Notes/Comments:



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# What is a Provider Appeal?

- An **appeal** allows providers dissatisfied with a claim reconsideration or authorization related denials *to formally dispute the denial and provide additional documentation* to BlueCross.
- Only one appeal is allowed per claim/authorization.
- Appeals must be filed and completed within a certain timeframe of receiving a reconsideration determination. *(Refer to timeliness grids for each line of business.)*
  - NOTE: If the reconsideration process identified the decision was related to medical necessity, you may be directed to a separate Utilization Management appeal form.
- For adjudicated claims to be appealed, you must provide adequate supporting documentation.
- If you still are dissatisfied following an appeal, the arbitration process begins.
  - Refer to the Provider Dispute Resolution Procedure documented in the BlueCross and BlueCare Provider Administration Manuals.

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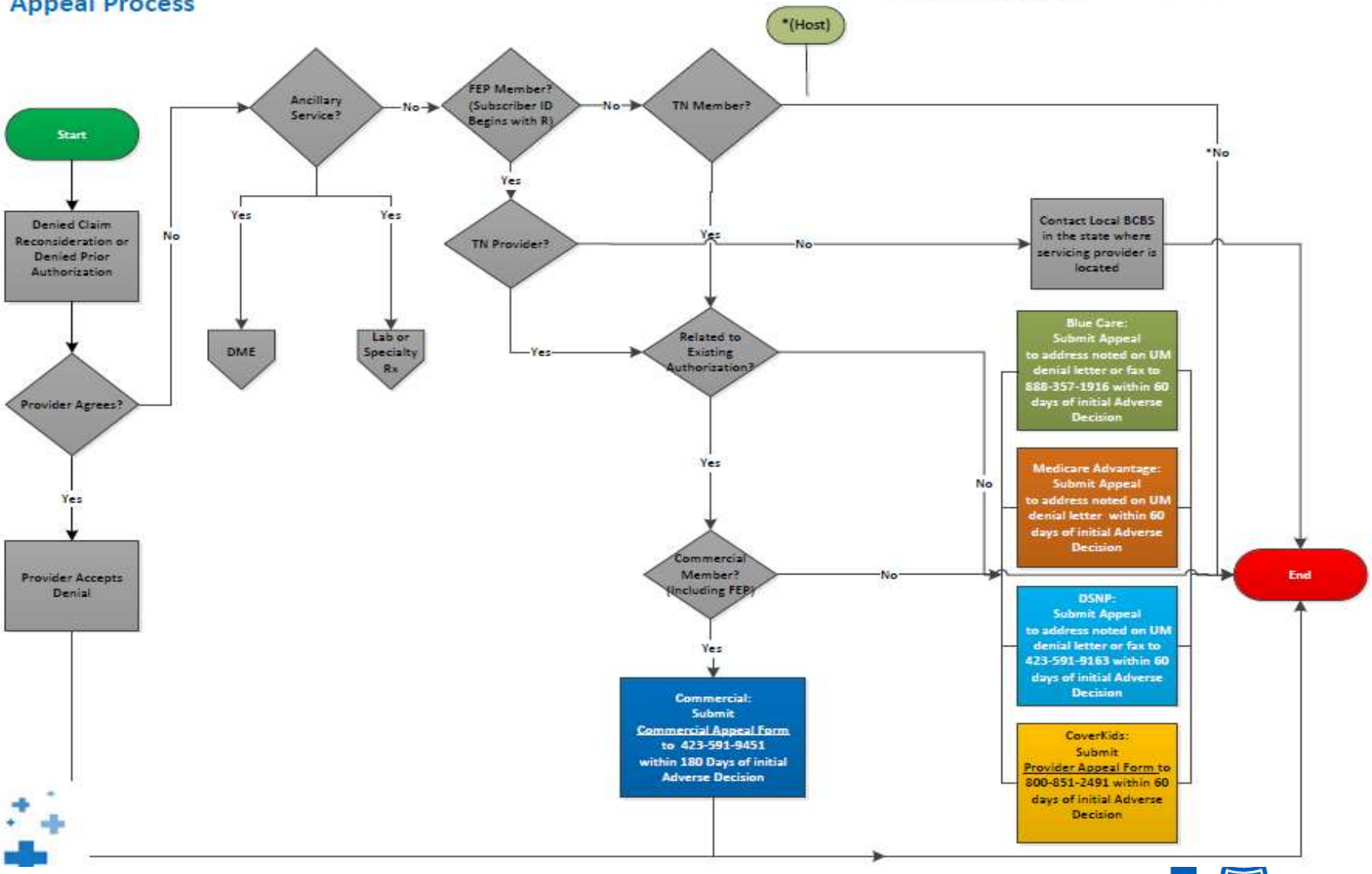
# What Does the Appeals Process Look Like?

## Appeal Process



# Formal Appeals

- You may file an appeal if you still are not satisfied with your claims outcome after the reconsideration process is complete or for authorization related denials

- Key questions:

  If CLAIM related: Have you filed a reconsideration, and was it denied?

  - ❑ YES: Move forward with the appeals process
  - ❑ NO: You will be redirected to the reconsideration process

  Do you agree with the reconsideration ruling?

  - ❑ YES: Accept the denial
  - ❑ NO: Move forward with a formal appeal

# Formal Appeals (continued)

- **Step 1:** For all appeals, are ancillary services affected?
  - YES: Claims may only be appealed:
    - If DME products were delivered or picked up in Tennessee
    - If Lab or Specialty Rx were ordered by a provider in Tennessee
    - **FEP only:** DME, Lab and Specialty Rx claims may be appealed if the provider filing the claim is in Tennessee
  - NO: Proceed to Step 2

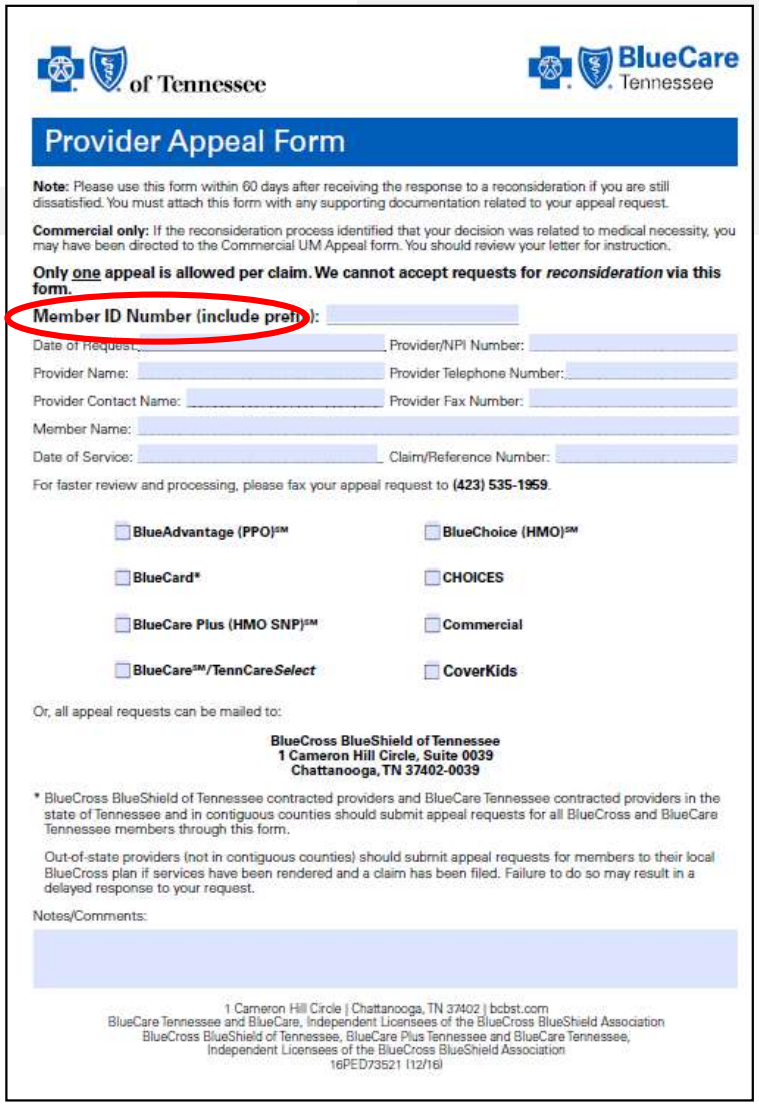
# Formal Appeals (continued)

- **Step 2:** Is the appeal related to an authorization request?

  - YES: The appeal is related to an authorization request
    - Is the authorization for a Commercial member?
      - YES: Fax the *Commercial UM Appeal Form* to (423) 591-9451
      - NO: Submit the *Provider Appeal Form* and fax to the dedicated fax number for each line of business:
        - BlueCare Tennessee: 1-888-357-1916
        - Medicare Advantage: No Fax Option
        - BlueCare Plus: (423) 591-9163
        - CoverKids: 1-800-851-2491
  - NO: There is no pending authorization
    - Submit the *Provider Appeal Form*

# Formal Appeals (continued)

- **Step 3:** Complete the provider appeal form
  - It is critical to **include the member ID number (including the prefix) at the top of the appeals form**.
  - This ensures the appeal is routed appropriately.



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## Provider Appeal Form

**Note:** Please use this form within 60 days after receiving the response to a reconsideration if you are still dissatisfied. You must attach this form with any supporting documentation related to your appeal request.

**Commercial only:** If the reconsideration process identified that your decision was related to medical necessity, you may have been directed to the Commercial UM Appeal form. You should review your letter for instruction.

**Only one appeal is allowed per claim. We cannot accept requests for *reconsideration* via this form.**

**Member ID Number (include prefix):**

Date of Request: Provider/NPI Number:

Provider Name: Provider Telephone Number:

Provider Contact Name: Provider Fax Number:

Member Name:

Date of Service: Claim/Reference Number:

For faster review and processing, please fax your appeal request to **(423) 535-1959**.

- ☐ **BlueAdvantage (PPO)℠**
- ☐ **BlueChoice (HMO)℠**
- ☐ **BlueCard®**
- ☐ **CHOICES**
- ☐ **BlueCare Plus (HMO SNP)℠**
- ☐ **Commercial**
- ☐ **BlueCare℠/TennCare*Select***
- ☐ **CoverKids**

Or, all appeal requests can be mailed to:

**BlueCross BlueShield of Tennessee**
**1 Cameron Hill Circle, Suite 0039**
**Chattanooga, TN 37402-0039**

* BlueCross BlueShield of Tennessee contracted providers and BlueCare Tennessee contracted providers in the state of Tennessee and in contiguous counties should submit appeal requests for all BlueCross and BlueCare Tennessee members through this form.

Out-of-state providers (not in contiguous counties) should submit appeal requests for members to their local BlueCross plan if services have been rendered and a claim has been filed. Failure to do so may result in a delayed response to your request.

Notes/Comments:

1 Cameron Hill Circle | Chattanooga, TN 37402 | bcbst.com
BlueCare Tennessee and BlueCare, Independent Licensees of the BlueCross BlueShield Association
BlueCross BlueShield of Tennessee, BlueCare Plus Tennessee and BlueCare Tennessee,
Independent Licensees of the BlueCross BlueShield Association
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# Timeliness

- Timeliness standards vary between lines of business because of different regulatory requirements.
- The following slides provide greater clarification on the timeliness standards for each line of business.

# Commercial Timeliness (Includes Federal Employee Program)

| Type of Dispute | Reconsideration Timeliness | Appeal Timeliness | *Non-Compliant | Arbitration |
|---|---|---|---|---|
| **Claim** | 18 months from Adverse Determination (Remit)<br><br>*Required before formal appeal*<br><br>Fax: (423) 535-1959 | 60 days from Reconsideration Determination<br><br>Fax: (423) 535-1959 | N/A | 60 days from Appeal Determination |
| **Authorization** (TN Members)<br><br>**FEP Members:** TN Providers | *Optional*<br>Before or during services but before formal appeal;<br>Submit through normal authorization processes: phone/fax/online | 180 days from Initial Adverse Determination<br><br>Submit through UM Appeal Form<br><br>Fax: (423) 591-9451<br>(Timeline aligns with NCQA UM8 - member appeals timeline.) | *60 days from Initial Adverse Determination (UM Letter/ Claim/ EOB) | 60 days from Appeal Determination |

# BlueCare/CoverKids Timeliness

| Type of Dispute | Reconsideration Timeliness | Appeal Timeliness | *Non-Compliant | Arbitration |
|---|---|---|---|---|
| **Claim** | *18 months* from Adverse Determination (Remit)<br><br>*Required before formal appeal*<br><br>Fax: (423) 535-1959 | 60 days from Reconsideration Determination<br><br>Fax: (423) 535-1959 | N/A | 60 days from Appeal Determination |
| **Authorization** | Optional<br>Before or during services<br><br>Submit through normal authorization processes: phone/fax/online | 60 days from Initial Adverse Determination<br><br>Fax: 1-888-357-1916<br>(Timeline for members is 30 days per the Bureau of TennCare. Providers are given additional 30 days per BCBST contract agreements.) | *60 days from Initial Adverse Determination (UM Letter/ Claim/ EOB) | 60 days from Appeal Determination |

# Medicare Advantage Timeliness

| Type of Dispute | Reconsideration Timeliness | Appeal Timeliness | *Non-Compliant | Arbitration |
|---|---|---|---|---|
| **Claim** | 18 months from Adverse Determination (Remit) *Required before formal appeal* Fax: (423) 535-1959 | 60 days from Reconsideration Determination Fax: (423) 535-1959 | N/A | 60 days from Appeal Determination |
| **Pre-Service Authorization** ***Considered Member Appeal*** | N/A | Must be filed within 60 days of the Original determination notice | N/A | 60 days from Appeal Determination |
| **Post-Service Authorization** | Peer to Peer prior to formal appeal | 60 days from *Initial* adverse determination (Timeline for members is 30 days per CMS. Providers are given additional 30 days per BCBST contract agreements.) | 60 days from Initial Adverse Determination (UM Letter/ Claim/ EOB) | 60 days from Appeal Determination |

# BlueCare Plus (Dual Special Needs Plan) Timeliness

| Type of Dispute | Reconsideration Timeliness | Appeal Timeliness | *Non-Compliant | Arbitration |
|---|---|---|---|---|
| **Claim** | 18 months from adverse determination (Remit)<br>*Required prior to formal appeal*<br><br>Fax: (423) 535-1959 | 60 days from Reconsideration Determination<br><br>Fax: (423) 535-1959 | N/A | 60 days from Appeal Determination |
| **Pre-Service Authorization (considered a member appeal)** | N/A | N/A | N/A | N/A |
| **Post-Service Authorization** | Optional; after initial denial but before formal appeal request<br><br>Provider can submit additional clinical for *re-evaluation* | 60 days from *Initial* Adverse Determination<br><br>Fax: (423) 591-9163<br>(Timeline for members is 30 days per the Bureau of TennCare. Providers are given additional 30 days per BCBST contract agreements.) | 60 days from Initial Adverse Determination (UM Letter/ Claim/ EOB) | 60 days from Appeal Determination |

# BlueCard Host (Non-Tennessee Members) Timeliness

| Type of Dispute | Reconsideration Timeliness | Appeal Timeliness | *Non-Compliant | Arbitration |
|---|---|---|---|---|
| **Claim** | 18 months from adverse determination (Remit)<br>*<u>Required</u> prior to formal appeal*<br><br>Fax: (423) 535-1959 | 60 days from Reconsideration Determination<br><br>Fax: (423) 535-1959 | N/A | 60 days from Appeal Determination |
| **Authorization (*Subject to Home plan guidelines)*** | Follow normal claim reconsideration | Follow normal appeal guidelines | N/A | N/A |

# Key Points to Remember

- Utilization management authorization appeals are handled by a medical team.
- Each line of business has dedicated UM appeal fax numbers.
- Claims appeals are handled by an administrative team.
- After the authorization appeals process is complete, you may not begin the claims appeal process. The next step is arbitration.
- Providers cover the costs associated with arbitration and independent reviews.
- The Provider Dispute Resolution process allows for one reconsideration, followed by one appeal per claim issue.
- Duplicate requests or improperly submitted forms will be returned without additional review.

# Common Terms

**Claim Reconsideration –** Allows providers who are dissatisfied with a claims outcome/denial *to request an additional review.*

**Authorization-related reconsideration/re-evaluations –** These reconsiderations/re-evaluations occur before or during services are being rendered and before billing occurs.

**Appeal –** Allows providers who are dissatisfied with a claim reconsideration or an adverse determination related to an authorization *to formally dispute the denial and provide BlueCross more documentation*.

**Arbitration –** Allows providers who are dissatisfied with a claim reconsideration and appeals process outcomes to seek resolution by a third party.

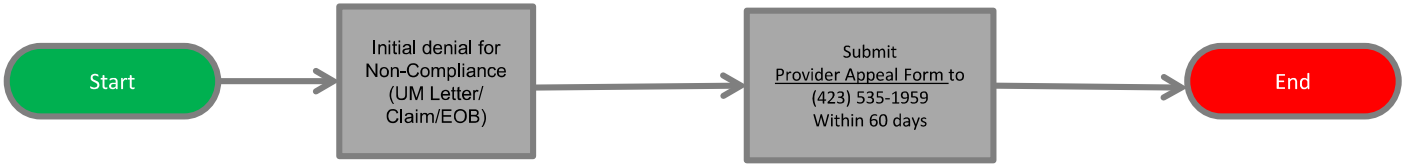
**Timeliness –** The amount of time providers have to pursue reconsideration or to appeal an adverse determination.

# Common Terms

**Non-Compliant –** When prior authorization is required, providers must obtain authorization before scheduled services and within 24 hours or the next business day of emergent services.

Failure to comply within specified authorization timeframes will result in a denial or reduced benefits from non-compliance, and **BlueCross participating providers will not be allowed to bill members for covered services rendered, except for any applicable copayment/deductible and coinsurance amounts.**

# Provider Appeals Process for Non Compliance



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# Resources

- Visit provider.bcbst.com/tools-resources/documents-forms for updated copies of each of the required form.
- Refer to the Provider Administration Manuals for each line of business, which can be found at: provider.bcbst.com/tools-resources/manuals-policies-guidelines