of Tennessee

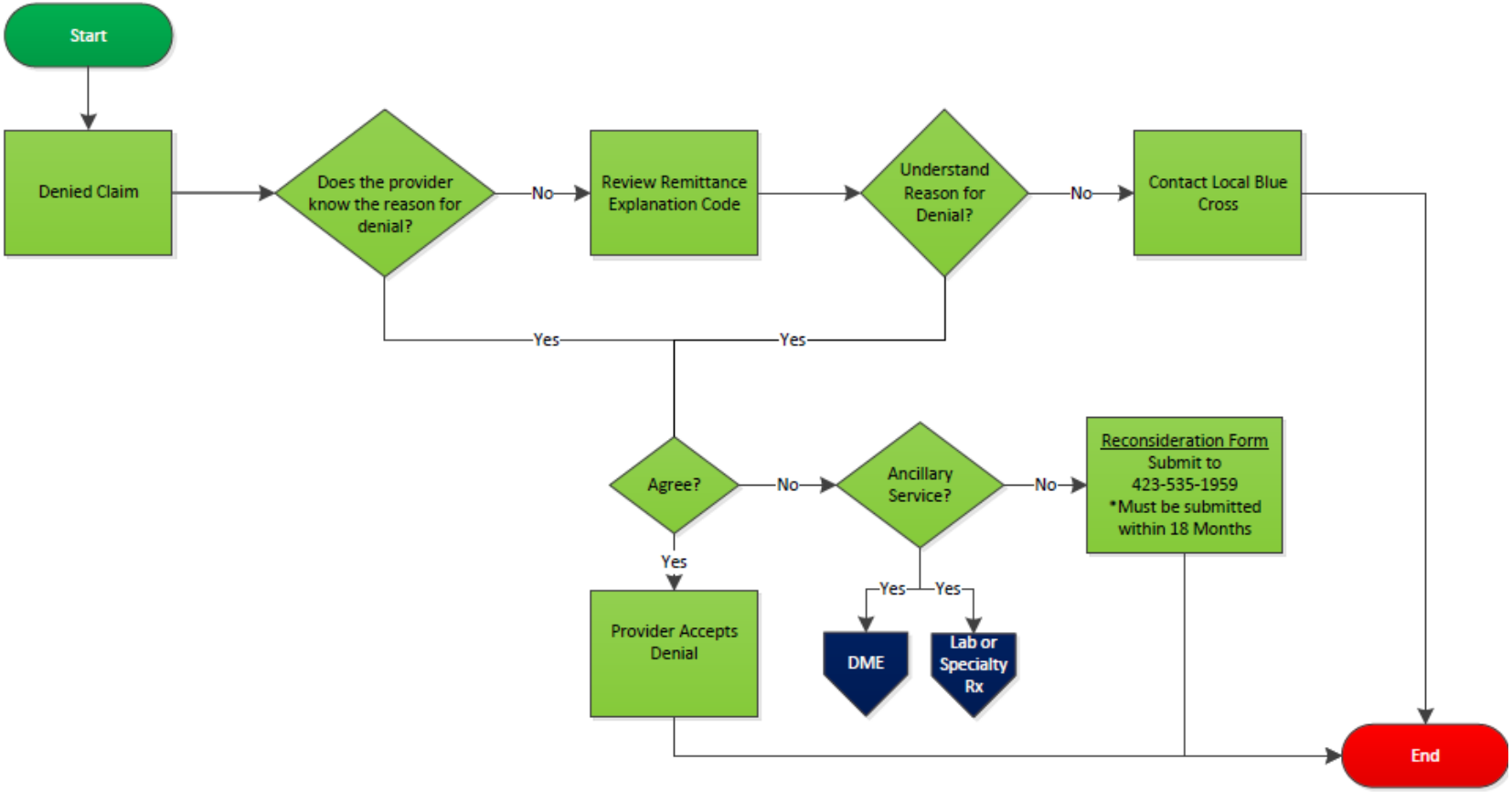
Provider Reconsideration and Appeals

Provider Tutorial

What is a Provider Reconsideration?

- A **reconsideration** allows providers dissatisfied with a claims outcome/denial to ask us questions. 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
- For adjudicated claims to be reconsidered, provide adequate supporting documentation.
- You may initiate a reconsideration by calling us or using the Provider Reconsideration Form (FEP must be written).
- If you still are dissatisfied after a reconsideration, you may file a formal appeal.

What Does the Reconsideration Process Look Like?



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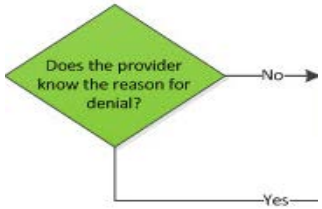
Reconsiderations: A Case Study

- The kickoff point for a provider 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)

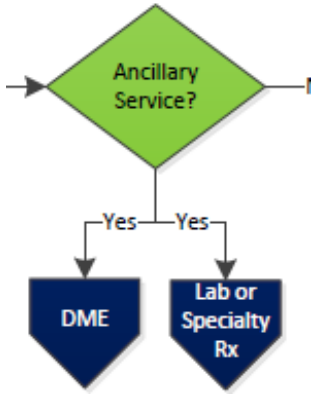
- **Step 1:** Does the provider understand why the claim was initially denied?



  - 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 535-1959 within 18 months of initial denial.



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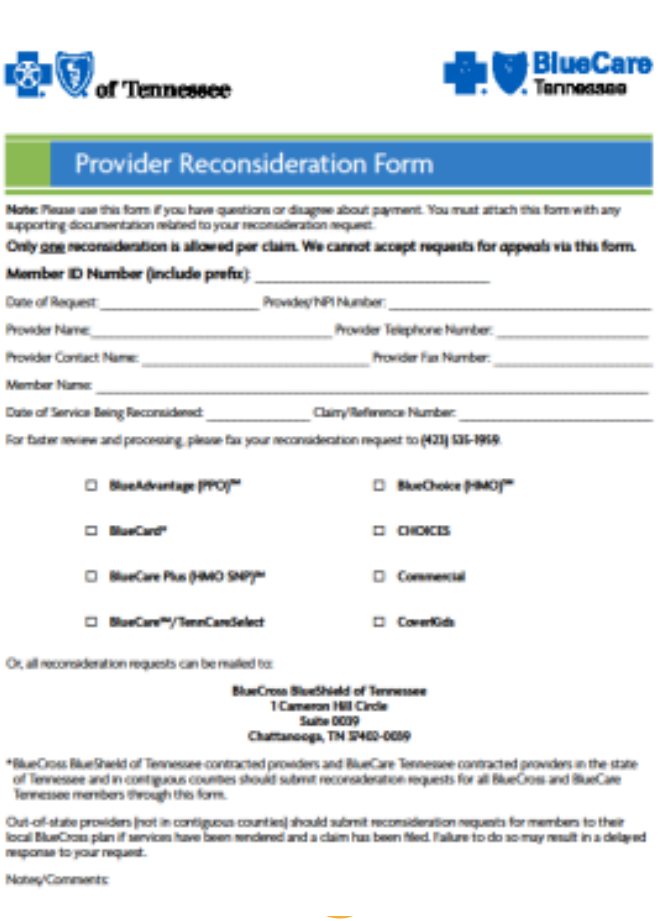
Submitting a Reconsideration

- **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®**
- ☐ **CHOICES**
- ☐ **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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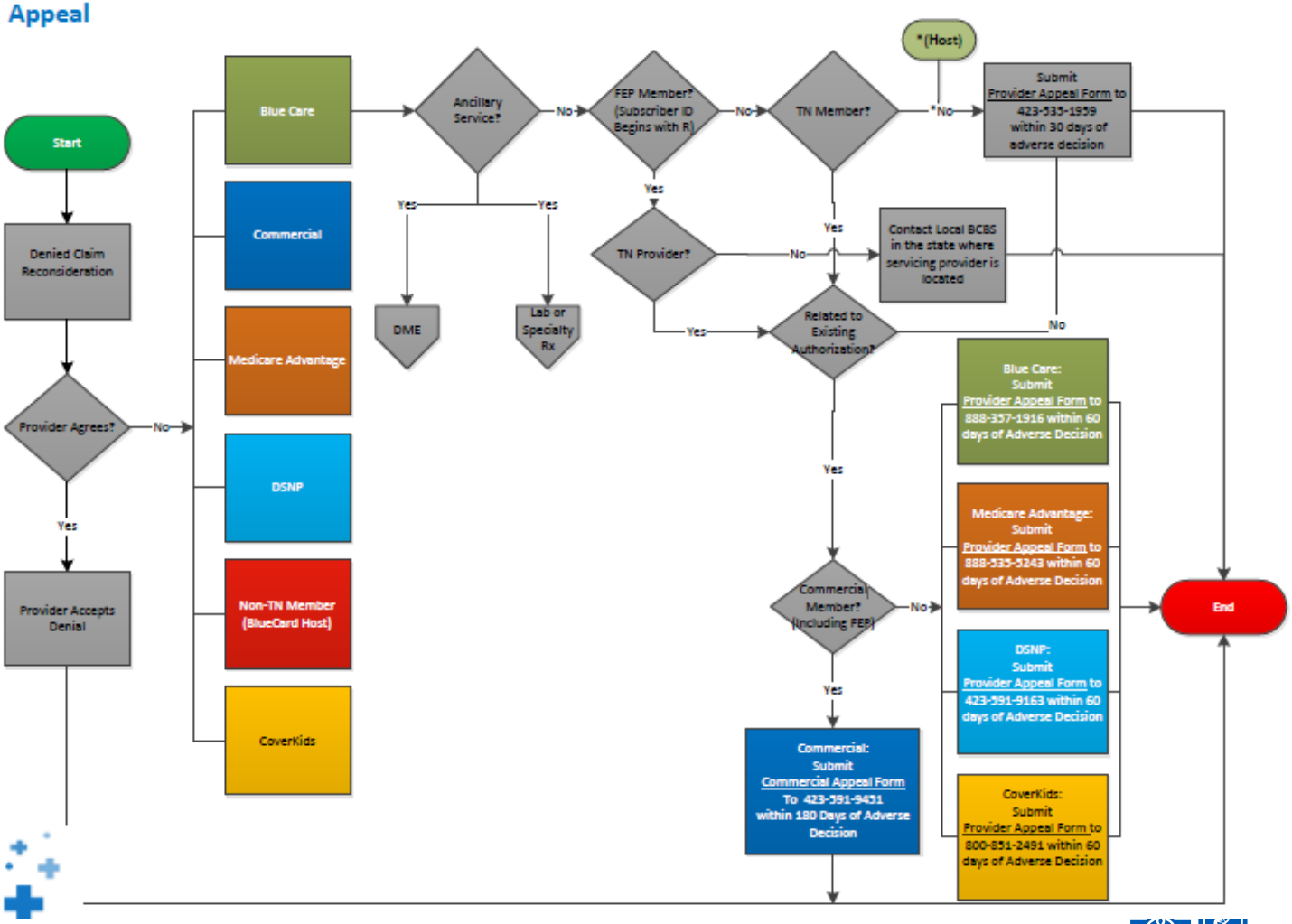
What is a Provider Appeal?

- An **appeal** allows providers dissatisfied with a claim reconsideration *to formally dispute the denial and provide additional documentation* to BlueCross.
- Only one appeal is allowed per claim.
- 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.

What Does the Appeals Process Look Like?

Denied Claim Reconsideration-Appeal



Formal Appeals

- You may file an appeal if you still are not satisfied with your claims outcome after the reconsideration process is complete.

- Key questions:

  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)

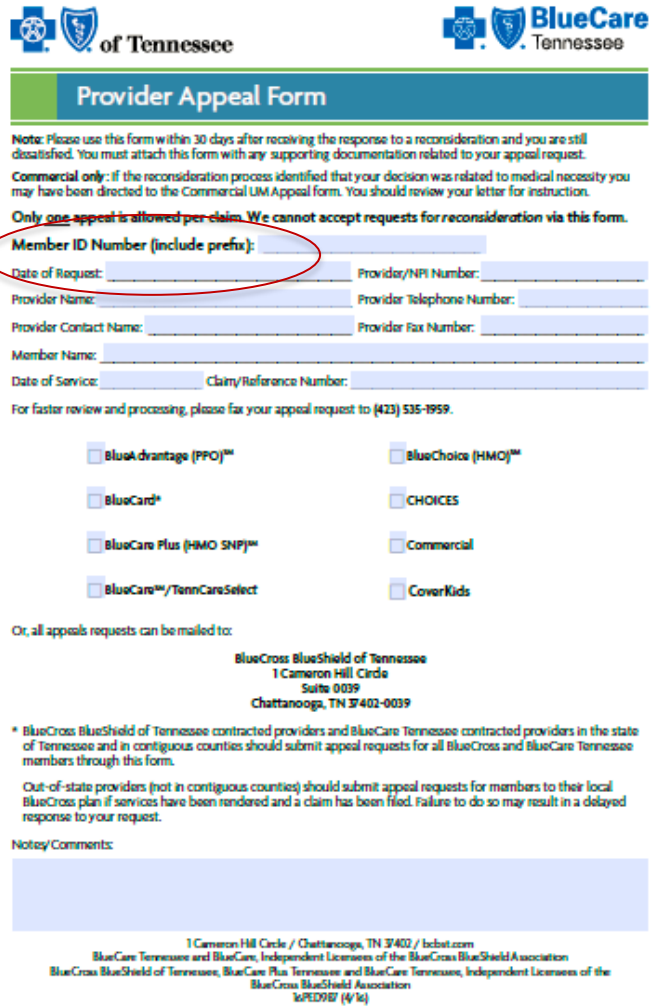
- **Step 1:** For all appeals, are ancillary services are affected?
  - YES: Claims may only be appealed:
    - If DME products were delivered or picked up in Tennessee
    - If Lab or Specialty Rx were ordered by a provider in Tennessee
    - **FEP only:** DME, Lab and Specialty Rx claims may be appealed 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: 1-888-535-5243
        - 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 30 days after receiving the response to a reconsideration and 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 appeals requests can be mailed to:

BlueCross BlueShield of Tennessee
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Chattanooga, TN 37402-0039

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Notes/Comments:

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) *Required before formal appeal* Fax: (423) 535-1959	30 days from Reconsideration Determination Fax: (423) 535-1959	N/A	30 days from Appeal Determination
Authorization (TN Members) **FEP Members:** TN Providers	*Optional* Before or during services but before formal appeal; Submit through normal authorization processes: phone/fax/online	180 days from Original Adverse Determination Submit through UM Appeal Form Fax: (423) 591-9451	*60 days from Adverse Determination (UM Letter/ Claim/ EOB)	30 days from Appeal Determination

BlueCare Timeliness

Type of Dispute	Reconsideration Timeliness	Appeal Timeliness	*Non-Compliant	Arbitration
Claim	*18 months* from Adverse Determination (Remit) *<u>Required</u> before formal appeal* Fax: (423) 535-1959	30 days from Reconsideration Determination Fax: (423) 535-1959	N/A	30 days from Appeal Determination
Authorization	<u>Optional</u> Before or during services Submit through normal authorization processes: phone/fax/online	60 days from Original Adverse Determination Fax: 1-888-357-1916	*60 days from Adverse Determination (UM Letter/ Claim/ EOB)	30 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	30 days from Reconsideration Determination Fax: (423) 535-1959	N/A	30 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	30 days from Appeal Determination
Post-Service Authorization	*Optional* "Re-evaluation"; prior to formal appeal	60 days from *most recent* determination notice Fax: 1-888-535-5243	60 days from Adverse Determination (UM Letter/ Claim/ EOB)	30 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) *Required prior to formal appeal* Fax: (423) 535-1959	30 days from Reconsideration Determination Fax: (423) 535-1959	N/A	30 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 Provider can submit additional clinical for *re-evaluation*	60 days from *Original* Adverse Determination Fax: (423) 591-9163	60 days from Adverse Determination (UM Letter/ Claim/ EOB)	30 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) *<u>Required</u> prior to formal appeal* Fax: (423) 535-1959	30 days from Reconsideration Determination Fax: (423) 535-1959	N/A	30 days from Appeal Determination
Authorization	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.

Common Terms

Reconsideration – Allows providers dissatisfied with a claims outcome/denial *to request additional information or ask us questions*.

Appeal – Allows providers dissatisfied with a claim reconsideration *to formally dispute the denial and provide BlueCross more documentation*.

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

Timeliness – The time you have to pursue reconsideration or appeal an adverse determination.
Non-Compliant – When prior authorization is required, you 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.**

Resources

- Visit www.bcbst.com/providers/forms/reconsideration-and-appeals.shtml for updated copies of each of the required forms.

- Refer to the Provider Administration Manuals for each line of business:
  - Commercial Provider Administration Manual
    www.bcbst.com/providers/manuals
  - BlueCare Tennessee Provider Administration Manual
    www.bcbst.com/providers/manuals
  - BlueCare Plus Provider Administration Manual
    http://bluecareplus.bcbst.com/provider-resources/