Member Appeal and Grievance Process

Carefully read the information in this packet and keep it for future reference. It has important information about how to appeal/grieve decisions Blue Cross Blue Shield of Arizona (BCBSAZ) makes about your health coverage.

Para obtener asistencia en Español, llame al 602 864-4884 or 1-800 232-2345 ext. 4884.
Kung kailangan niyo ang tulong sa Tagalog tumawag sa 1-877- 475-4799.
如果需要中文的帮助，请拨打这个号码 1-877-475-4799.
Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-475-4799.

Decisions You Can Appeal or Grieve

STANDARD APPEAL

Denials of Medical Necessity, Contract Coverage, Investigational services

EXPEDITED APPEAL

When your provider certifies that your condition is urgent and services have not been received

MEMBER GRIEVANCE

Disputes about Member Cost share and Plan Allowed Amount

A denial or partial denial occurs when Blue Cross® Blue Shield® of Arizona (BCBSAZ), as issuer of your health benefit plan ("plan"), makes any of the following decisions:

- Denies your request for pre-certification of a service you haven't yet received;
- Denies a claim for services already received;
- Denies, reduces, or terminates your plan benefits;
- 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

The timeframe to dispute a decision you disagree with:

- If we denied a claim or a pre-certification for a service, you have 2 years from the date of denial to request an appeal.
- If you disagree with how we paid the claim (i.e., copay, deductible, coinsurance, level of benefits, etc.), you have 1 year 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".)

Written Notification of Denial

When we make a denial decision, we send you written notice in the form of

1. An "Explanation of Benefits" (EOB) document,
2. A monthly member health statement, or
3. A letter

All of these documents include information about your right to appeal or grieve the decision.

BCBSAZ also contracts with independent third parties to administer some benefits for services which can include:

- Chiropractic services (handled by the Chiropractic Benefits Administrator or the "CBA"),
- Vision hardware (handled by the Vision Hardware Administrator or the "VHA").

These and other vendors may issue some of these decisions and may perform the review at one or more levels. References in this brochure to BCBSAZ will include the CBA, VHA, and any other vendors when they are administering benefits for BCBSAZ.

Description of the Appeal and Grievance Processes

1. You have the right to file an appeal or grievance, free of charge.
2. Information on where to file an appeal or grievance is included in the written denial notice, (Your Explanation of Benefits statement (EOB), your monthly health statement, or a denial letter.) Your notice will tell you:
    a. Who made the precertification decision or processed your claim (BCBSAZ or a vendor).
    b. Where to file the appeal.

Refer to your benefit book for additional information.

1. We cannot change the scope of your coverage or rewrite your cost share amount.
2. We provide a full and fair review of any submitted documents.
3. Standardized forms are found at the back of this brochure but are not required.
4. Consumer assistance is available from the Arizona Department of Insurance and Financial Institutions (AZ DIFI)

STANDARD APPEALS

First Level—Initial Internal Appeal

1. You have 2 years from the date of the decision to file an appeal.
2. You and your provider should send us any information you want us to consider in the appeal.
3. Be sure to include at least the following information in your request:
    - The decision or action you disagree with and wish to appeal
    - Why you think our original decision is wrong
    - What you are asking BCBSAZ to do differently, and
    - Any medical records that support your request
    - There are forms at the end of this packet that you or your provider can use, but they are not required forms

Remember to include everything you want us to consider in your appeal

4. For issues involving medical judgment, the review is performed by a health care professional who has the appropriate training and experience in the field of medicine involved in the case.
5. The reviewer is someone who was not involved in the original denial decision and is not compensated, rewarded or promoted for upholding the original decision.

6. See end of brochure for the list of addresses where you can send your appeal. This information will also be in your decision notice.
7. BCBSAZ acknowledges the receipt of your appeal within 5 business days and sends a written decision to you and your provider:
   - Within 15 days for appeals related to precertification denials
   - Within 30 days for appeals related to claim denials for services already provided.
8. You may have a second internal level of appeal if your plan allows. The process varies depending on whether you have group or individual coverage, and whether your plan is grandfathered or non-grandfathered. Your benefit book shows whether your plan is a grandfathered plan.

Second Level Internal Appeal

Second level internal appeals are available for members of Group Plans and Grandfathered Individual Plans. Members of non-grandfathered Individual Plans go directly to an External Independent Review.

1. If your appeal is eligible for external review, BCBSAZ may skip the second level and send to the Arizona Department of Insurance and Financial Institutions (AZ DIFI) for an independent, external review.
2. You have 60 days to send a written request for a Level 2 review after receiving aLevel 1 denial determination.
3. BCBSAZ acknowledges the receipt of your appeal within 5 business days and sends a written Level 2 decision to you and your provider:
   - Within 15 days for appeals related to precertification denials
   - Within 30 days for appeals related to claim denials for services already provided.

Standard External Review

1. If you still disagree with the decision, and the case involves questions of medical judgment or a rescission of coverage the case can be sent for an external independent medical review.
   a. Cases based on "medical judgment" include:
      i. Medical necessity
      ii. Medical appropriateness
      iii. Health care setting
      iv. Level of care
      v. Benefit effectiveness
      vi. Investigational or experimental treatment

Be sure to include any new information you want considered in your appeal

2. You may also appeal contract benefit denials. The Arizona Department of Insurance and Financial Institutions (AZ DIFI) decides contract coverage appeals.
3. External review is not available for denials based on lack of member eligibility or for payment disputes that do not involve questions of medical judgment.

4. You have **up to 4 months** from the date of the final internal review decision to submit a written request for external review.
5. After getting your request, BCBSAZ has 5 business days to decide if your request is eligible for external review.
   - BCBSAZ notifies you within one additional business day if your case is not eligible for external review or if your submission is incomplete.
   - If your submission is incomplete, you have up to the 4 month period to submit any missing information.
   - If the time has expired, you have 48 hours after you received BCBSAZ's notice of incomplete submission to send the missing information.
6. BCBSAZ sends the external review to the Arizona Department of Insurance and Financial Institutions (AZ DIFI). The AZ DIFI decides contact coverage cases and refers medical necessity cases and issues of medical judgment to an external Independent Review Organization (IRO).

STANDARD External Review Appeals Submitted to the Arizona Department of Insurance and Financial institutions (AZ DIFI)

1. The time periods for a Medical Necessity Case or a case involving issues of medical judgment:

a. Within 5 business days of receiving the appeal from BCBSAZ, the AZ DIFI sends all of the information to an external IRO.
b. The IRO has 21 days to make a decision and send it to the AZ DIFI.
c. The AZ DIFI must mail the IRO's decision to you, your treating provider and to BCBSAZ within 5 business days.

2. The time periods for a Contract Coverage Case:

a. Within 15 business days of receiving the appeal from BCBSAZ the AZ DIFI:
   - Must decide if the service is covered, and,
   - Send its decision to you, your treating provider and BCBSAZ.

b. If the AZ DIFI thinks your contract coverage case also involves medical issues, it will send your case to an IRO. If so:
   - The IRO has 21 days to make a decision and send to the AZ DIFI.
   - The AZ DIFI has 5 days business days to send the decision to you, your treating provider and BCBSAZ.

3. If the AZ DIFI or an IRO reverses or modifies the decision in your favor:

a. BCBSAZ complies with the decision.
b. For cases involving medical issues decided by an IRO, the decision is final, but subject to judicial review.
c. For contract coverage cases decided by the AZ DIFI, if you disagree with the final decision, you may ask for a hearing with the Office of Administrative Hearings (OAH).
d. If BCBSAZ disagrees with the AZ DIFI's final decision on a contract case, it may also request a hearing before OAH.
   - BCBSAZ authorizes the service while the OAH hearing is pending.
e. A party must request the OAH hearing within 30 days of the AZ DIFI's decision.
   - OAH promptly schedules and completes a hearing.

EXPEDITED APPEALS

Available Only for a Denial for urgent services not yet received

If your treating provider certifies that the condition qualifies as urgent, then BCBSAZ treats the appeal as expedited.

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, cause a significant negative change in the member's medical condition at issue, or subject the member to severe pain that cannot be managed without the requested service.

First Level—Initial Expedited Appeal

1. You and your provider should promptly file your request for expedited appeal. Make sure to send us any information you want us to consider in the appeal.
2. Be sure to include at least the following information in your request:
    - The decision or action you disagree with and wish to appeal
    - Why you think our original decision is wrong
    - What you are asking BCBSAZ to do differently, and
    - Any medical records that support your request
    - There are forms at the end of this packet that you or your provider can use, but they are not required forms
3. The review is performed by a health care professional who has the appropriate training and experience in the field of medicine involved in the case.
4. The reviewer is someone who was not involved in the original denial decision and is not compensated, rewarded or promoted for upholding the original decision.
5. See end of brochure for a list of where to send your appeal. This will also be included in the decision notice.
6. We have one business day (not to exceed 72 hours) to notify you and your provider of the decision by phone and by mail.
7. You may have a second internal expedited level of appeal if your plan allows. The process varies depending on whether you have group or individual coverage, and whether your plan is grandfathered or non-grandfathered. Your benefit book shows whether your plan is a grandfathered plan.

Second Level—Internal Expedited Appeal

Second level internal expedited appeals are available for members of Group Plans and Grandfathered Individual Plans. Members of non-grandfathered Individual Plans go directly to an External Independent Review.

1. We have 1 business day (not to exceed 72 hours) to notify you and your provider of the decision by phone and by mail.
2. If your appeal is eligible for external review, BCBSAZ may skip the second expedited level and send to the Arizona Department of Insurance and Financial Institutions (AZ DIFI) for an expedited, independent, external review.

Expedited External Review

1. If you still disagree with the decision, and the case involves questions of medical judgment or a rescission of coverage the case can be sent for an external independent medical review.
    a. Cases based on "medical judgment" include:
        1. Medical necessity
        2. Medical appropriateness
        3. Health care setting
        4. Level of care
        5. Benefit effectiveness
        6. Determination that a treatment is investigational or experimental
2. You may also appeal contract benefit denials. The Arizona Department of Insurance and Financial Institutions (AZ DIFI) decides contract coverage appeals.
3. External review is not available for denials based on lack of member eligibility or for payment disputes that do not involve questions of medical judgment.
4. You have up to 4 months from of the date of the final internal review decision to submit a written request for external review.
5. After getting your request, BCBSAZ has 1 business day to decide if your request is eligible for external review.
    - BCBSAZ notifies you within one additional business day, if your case is not eligible for external review or if your submission is incomplete.
    - If your submission is incomplete, you have up to the 4 month period to submit any missing information.
    - If the time has expired, you have 48 hours after you received BCBSAZ's notice of incomplete submission to send the missing information.
6. BCBSAZ sends the external review to the Arizona Department of Insurance and Financial Institutions (AZ DIFI) for review. The AZ DIFI decides contract coverage cases and refers medical necessity cases and issues of medical judgment to an external Independent Review Organization (IRO).

EXPEDITED External Review Appeals Submitted to the Arizona Department of Insurance and Financial Institutions (AZ DIFI)

1. The time periods for a Medical Necessity Case or a case involving issues of medical judgment:

- Within 2 business days of receiving the appeal from BCBSAZ, the AZ DIFI sends all of the information to an external IRO.
- Within 72 hours of receiving the information, the IRO makes the decision and sends it to the AZ DIFI.
- Within 1 business day of receiving the IRO's decision, the AZ DIFI mails the notice to you, your treating provider and to BCBSAZ.

2. The time periods for a Contract Coverage Case:

a. Within 2 business days of receiving the appeal from BCBSAZ, the AZ DIFI must:

- Decide if the service is covered, and
- Send its decision to you, your treating provider and BCBSAZ.

b. If the AZ DIFI thinks your contract coverage case also involves medical issues, it will send your case to an IRO. If so:
   - The IRO has 72 hours to make the decision and send the decision to the AZ DIFI.
   - The AZ DIFI has 1 business day to send the decision to you, your treating provider and BCBSAZ.

3. If the AZ DIFI or an IRO reverses or modifies the decision in your favor:

a. BCBSAZ complies with the decision.

b. For cases involving medical issues decided by an IRO, the decision is final but subject to judicial review.

c. For contract coverage cases decided by the AZ DIFI, if you disagree with the final decision, you may ask for a hearing with the Office of Administrative Hearings (OAH).

d. If BCBSAZ disagrees with the AZ DIFI's final decision on a contract case, it may also request a hearing before OAH.
   - BCBSAZ authorizes the service while the OAH hearing is pending.

e. A party must request the OAH hearing within 30 days of the AZ DIFI's decision.
   - OAH promptly schedules and completes a hearing.

MEMBER GRIEVANCES

Appeal Process to Dispute Decisions Related to Member Cost Share

First Level—Initial Member Grievance

1. You have 1 year from the date of the decision or action to file a grievance.
   a. BCBSAZ has discretion to extend this time limit for good cause:
      - Death in your immediate family
      - Serious illness for either you or someone in your immediate family
2. Timeframes for BCBSAZ to notify you of its decision
   a. Pre-service or precertification issues:
      - Within 15 days from the date BCBSAZ receives your grievance request

b. Post –Service claims:
   - Within 30 days from the date BCBSAZ receives your grievance request

3. For non-grandfathered Individual Plans, this decision concludes your grievance process. There is no further right to challenge the decision.

Second Level Member Grievance

1. This level is only available to members of Group Plans and grandfathered Individual Plans
2. You have 60 days to send a written request for Level 2 after receiving the Level 1 decision.

3. Timeframes for BCBSAZ to notify you of its decision:
    a. Pre-service or precertification issues:
        - Within 15 days from the date BCBSAZ receives your grievance request
    b. Post–Service claims:
        - Within 30 days from the date BCBSAZ receives your grievance request
            a. BCBSAZ may extend the time limit if necessary and in accordance with applicable law by notifying you in writing including the reason for the extra time.
4. If you still disagree with BCBSAZ's decision:
    a. For questions about member cost share, that do not involve questions of medical judgment, no further review is available.
    b. You may have other legal recourse to challenge BCBSAZ's decision in court.

Authorizing someone else to file the appeal or grievance on your behalf

You can designate an "authorized representative" to file an appeal or grievance on your behalf. That person has the right to make decisions about your case (for example, whether to seek review at a higher level, if available). BCBSAZ sends information about the progress of your case to the representative, with a copy to you.

- The following individuals are authorized to appeal or grieve a decision and do not need any special authorization form:
- Your treating provider acting on your behalf; and
- A parent on behalf of a minor.
- Also, the following individuals may appeal or grieve a decision for you, if you send BCBSAZ the required proof of authority:

Third Party Representative	Proof of Authority
Member's Legal Guardian	Official copy of the court order appointing the guardian.
Your Agent	Power of Attorney that complies with A.R.S. § 14-5501 (or equivalent statute from other state) authorizing the agent to appeal or grieve a healthcare decision; or Health care power of attorney that complies with A.R.S. § 36-3221 (or equivalent) and authorizes the agent to make health care treatment decisions for you.
Your Surrogate	Someone who qualifies as a surrogate as defined by A.R.S. §36-3231 (or equivalent statute from another state) 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

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 to us in writing the scope of the third party's authorization. We do not recognize the third party's authority until we receive your confirmation.

You cannot use a Confidential Information Release Form (CIRF) to designate an authorized representative to bring forth an appeal/grievance. 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.

Medical Records

Under Arizona law (A.R.S. §12-2293), you must request medical records and 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 may have the right to charge you for copies.

If you have an authorized representative, that person can request copies of your medical records. On the written request of a patient or the patient's health care decision maker for access to or copies of the patient's medical records and payment records, the health care provider in possession of the record shall provide access to or copies of the records to the patient or the patient's health care decision maker.

If you reside outside the state of Arizona, the laws that govern medical records and providers in your state may vary

Confidentiality

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.

Additional Rights

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.

Filing complaint with the Arizona Department of Insurance and Financial Institutions

Arizona law (A.R.S. §20-2533(F)) requires you to exhaust the appeal process before you file a complaint with the AZ DIFI if your complaint involves a matter that could be appealed. You must pursue the health care appeals process before the AZ DIFI can investigate your complaint.

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.

If you disagree with how we processed your claim

Call BCBSAZ Customer Service Monday through Friday, 8 a.m. to 4:30 p.m. MST (except holidays) at these numbers to explain your situation:

Maricopa County 602 864-4400
Pima County 520 745-1883
Statewide 800 232-2345

For an appeal or member grievance call, fax, or write to:	Chiropractor Services (not all plans have the CBA)
BCBSAZ Attn: Medical Appeals & Grievances Specialist P.O. Box 13466–Mail stop A116 Phoenix, AZ 85002-3466 Phone: 602-544-4938 or 866-595-5998 Fax: 602-544-5601 Email: appeals@azblue.com	American Specialty Health Networks, Inc. Attn: Appeals Coordinator P.O. Box 509001 San Diego, CA 92150-9001 Phone: 1-800-972-4226 Fax: 1-877-248-2746

Appeal Resources

BCBSAZ customer service representatives can answer questions about the appeal process and help you with filing an appeal. The BCBSAZ customer service number is 602-864-4400 or 800-232-2345 (toll free).

You can also contact the U.S. Department of Labor—Employee Benefits Security Administration at 1-866-444-EBSA (3272). You may also call the Arizona Department of Insurance and Financial Institutions (AZ DIFI) Consumer Assistance Office at 602-364-2499 or 800-325-2548.

Appeal/Grievance Request Form

You may use this form to explain the need for an urgent appeal, but you are not required to use it.

BlueCross BlueShield Arizona

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Provider Information

Member Name _____

Member ID # _____

Name of representative pursuing appeal, if different than above _____

Phone # _____

Mailing Address _____

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, cause a significant negative change in your medical condition, 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 would like BCBSAZ to do differently:

_____

_____

_____

If you have questions about the appeal or grievances process or need help to prepare your request, please call BCBSAZ at **602-864-4400** or **800-232-2345.**

Make sure that 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 attach the certification from your treating provider if you are seeing an expedited review. Send to:

Blue Cross Blue Shield of Arizona
Medical Appeals and Grievances Department
P.O. Box 13466, Mail stop A116
Phoenix, AZ 85002-3466
Phone: 602-544-4938 or 866-595-5998
Fax: 602-544-5601
Email: appeals@azblue.com

Signature of member or authorized representative _____ Date _____

Provider Certification Form for Expedited Appeal

BlueCross BlueShield Arizona

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Is the appeal for a service that the patient has not yet received? ☐ ***Yes*** ☐ ***No***
If "Yes", continue with this form.
If "No", the patient must pursue the standard appeal process and cannot use the expedited appeals process.

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, cause a significant negative change in their medical condition, or subject the patient to severe pain that cannot be adequately managed without the requested service.

Provider's Signature: _____ Date _____

Printed Name: _____

If you have questions about the appeals process or need help to prepare your appeal, please call BCBSAZ at 602 864-4400 or 800 232-2345.

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