Blue Cross Blue Shield of North Dakota
Provider Inquiry, Appeal and Grievance Process

This document identifies the inquiry, appeal and grievance definitions, as well as the different types of each. The inquiry, appeals and grievance process does not include questions related to fee schedule amounts, reimbursement or the DRG Validation Program.

Inquiry

An inquiry is defined as a health care provider initiating a request to BCBSND to prior approve, preauthorize or research a benefit or payment. Providers may initiate an inquiry or appeal by contacting Provider Service. The table below identifies the types of inquiries and time frames that apply to each.

Type of Inquiry	Time Frame for BCBSND to Respond
Pre-Service Claim for Benefits	Written response within 15 calendar days
Emergency Claim for Benefits	Verbal response within 72 hours, followed by a written response within 3 calendar days
Retrospective Review Claim for Benefits	Written response within 30 calendar days
Post-Service Claim for Benefits	Written response within 30 calendar days

Pre-Service Claim for Benefits Inquiry
A Pre-Service Claim for Benefits Inquiry is defined as a request, either verbal or written, that is conditioned on a member obtaining approval in advance of obtaining the benefit or service.

There are two levels of pre-service inquiry:
- Pre-service claim for benefits
- Emergency claim for benefits

BCBSND will respond in writing within 15 calendar days to a pre-service claim for benefits inquiry.

An Emergency Claim for Benefits Inquiry is when the timeframe for the Pre-Service Claim for Benefits inquiry would seriously jeopardize the member's life, health or ability to regain maximum function. If the services in question meet the definition of Emergency Medical Condition, the inquiry will be considered emergent.

An Emergency Medical Condition is defined as a medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson acting reasonably and possessing an average knowledge of health and medicine to believe that the absence of immediate medical attention could reasonably be expected to result in serious impairment to bodily function, serious dysfunction of any bodily organ or part, or would place the person's health, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

Retrospective Review Claim for Benefits Inquiry
A Retrospective Review Claim for Benefits Inquiry is defined as a request, either verbal or written, for a medical review of services that is conditioned on a member obtaining approval in advance of obtaining the benefit or service; however advance approval was not obtained and services were provided to the member. Determinations regarding Retrospective Review Claim for Benefits are based solely on the medical information available to the attending physician or ordering health care provider at the time the medical care was provided. The health care provider is responsible for providing BCBSND with a Retrospective Review Claim for Benefits within 180 days after the date the benefits or services offered under their benefit plan were incurred. Any inquiry received after 180 days will be returned to the health care provider without review.

Post-Service Claim for Benefits Inquiry
A Post-Service Claim for Benefits Inquiry is defined as a written request expressing disagreement with a claim that has been processed correctly according to the member's benefit plan that is not conditioned on a member obtaining approval in advance of obtaining the benefit or service. The health care provider has 180 days from the claim processed date to make such an inquiry. BCBSND will respond to these inquiries within 30 calendar days upon receipt of all relevant information. Any inquiry received after 180 days will be returned to the health care provider without review.

The inquiry determination will be provided in writing, by telephone or through the health care provider remittance. Post-Service Claim for Benefits inquiries will include claim adjustments.

Appeal

An Appeal is defined as a health care provider expressing disagreement with an inquiry determination. There are Pre-Service Claim for Benefits Appeals, Retrospective Review Claim for Benefits Appeals and Post-Service Claim for Benefits Appeals.

Pre-Service and Retrospective Review Appeals can be either verbal or written; however, Post-Service Appeals must be written.

Pre-Service Claim for Benefits Appeals occur before the service in question is rendered. The Pre-Service Claim for Benefits Appeals is further categorized as Standard and Emergency. Retrospective Review Claim for Benefits Appeals and Post-Service Claim for Benefits Appeals occur after the service has been rendered. The table below identifies the types of Appeals and time frames that apply to each.

Type of Appeal	Time Frame for BCBSND to Respond
Pre-Service Claim for Benefits*	Written response within 30 calendar days
Emergency Claim for Benefits*	Verbal response within 72 hours, followed by a written response within 3 calendar days
Retrospective Review Claim for Benefits*	Written response within 30 calendar days
Post-Service Claim for Benefits*	Written response within 60 calendar days

*See definitions under Inquiry.

Appeal Process
A health care provider may submit written comments, documents and records, or other documents relating to the case to appeal an inquiry determination. The appeal must be received within 180 days from the date BCBSND notifies the health care provider of the inquiry determination. The health care provider must specifically state the nature of the appeal and include all supporting information and rationale for overturning the inquiry determination. Any Appeal received after 180 days will be returned to the health care provider without review.

BCBSND will take all the information into account during the Appeal process without regard to whether the information was submitted or considered in the initial consideration of the case.

A BCBSND Medical Director/Medical Consultant who was not involved in the original inquiry determination will review the appeal. This individual will be board certified in the same or similar specialty as the provider who typically manages the medical condition appealed and is not the individual who made the original non-certification, or the subordinate of such an individual.

BCBSND will implement the decision of the appeal if the initial denial is overturned and respond with a written notice of the final determination including an explanation of the reason for the determination within the time frames shown above. Emergent Pre-Service Appeal response will be communicated via telephone and writing.

Contact Information
For questions or assistance in filing Inquiries and Appeals:

- Members can contact Member Services 1-800-342-4718
- Providers can contact Provider Service 1-800-368-2312

Grievance

A grievance is defined as a written or oral complaint if the complaint is submitted by or on behalf of a covered Member that involves one of the following:

- A quality of care grievance is a complaint related to the quality of health care services provided by a Physician or Health Care Provider.
- A quality of service grievance is a complaint related to the non-clinical services received by a Member that may include but are not limited to complaints regarding access to care, waiting times, claims payment or reimbursement for health care services.
- An administrative grievance is any complaint involving the terms of coverage and plan services administered by BCBSND.

Grievance Process
The Member, the Member's authorized representative and the Member's Participating Health Care Provider can file a grievance or receive assistance with filing and/or completing a grievance by contacting Member Services at the following phone numbers and address:

701-277-2227 or 1-800-342-4718
or
Blue Cross Blue Shield of North Dakota
4510 13th Avenue South
Fargo, North Dakota 58121

Grievances may be filed orally or in writing no later than 180 calendar days after the incident. All Grievances will be acknowledged upon receipt. The Member or Member's authorized representative will receive a response within 30 days.

Healthy Steps
Provider Inquiry, Appeal and Grievance Process

This document identifies the inquiry, appeal and grievance definitions, as well as the different types of each. The inquiry and appeals process does not include questions related to fee schedule amounts, reimbursement or the DRG Validation Program.

Inquiry

An inquiry is defined as a health care provider initiating a request to BCBSND to prior approve, preauthorize or research a benefit or payment. Providers may initiate an inquiry or appeal by contacting Provider Service. The table below identifies the types of inquiries and time frames that apply to each.

Type of Inquiry	Time Frame for BCBSND to Respond
Pre-Service Claim for Benefits	Written response within 14 calendar days
Emergency Claim for Benefits	Verbal response within 72 hours, followed by a written response within 3 calendar days
Retrospective Review Claim for Benefits	Written response within 30 calendar days
Post-Service Claim for Benefits	Written response within 30 calendar days

Pre-Service Claim for Benefits Inquiry
A Pre-Service Claim for Benefits Inquiry is defined as a request, either verbal or written, that is conditioned on a member obtaining approval in advance of obtaining the benefit or service.
There are two levels of pre-service inquiry:

- Pre-service claim for benefits
- Emergency claim for benefits

BCBSND will provide a determination for a Standard Pre-Service Claim for Benefits as expeditiously as the Member's health condition requires and within the time frames established that may not exceed 14 calendar days.

BCBSND will respond in writing within 14 calendar days to a pre-service claim for benefits inquiry.

An Emergency Claim for Benefits Inquiry is when the timeframe for the Pre-Service Claim for Benefits inquiry would seriously jeopardize the member's life, health or ability to regain maximum function. If the services in question meet the definition of Emergency Medical Condition, the inquiry will be considered emergent.

An Emergency Medical Condition is defined as a medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson acting reasonably and possessing an average knowledge of health and medicine to believe that the absence of immediate medical attention could reasonably be expected to result in serious impairment to bodily function, serious dysfunction of any bodily organ or part, or would place the person's health, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

Retrospective Review Claim for Benefits Inquiry
A Retrospective Review Claim for Benefits Inquiry is defined as a request, either verbal or written, for a medical review of services that is conditioned on a member obtaining approval in advance of obtaining the benefit or service; however advance approval was not obtained and services were provided to the member. Determinations regarding Retrospective Review Claim for Benefits are based solely on the medical information available to the attending physician or ordering health care provider at the time the medical care was provided. The health care provider is responsible for providing BCBSND with a Retrospective Review Claim for Benefits within 180 days after the date the benefits or services offered under their benefit plan were incurred. Any inquiry received after 180 days will be returned to the health care provider without review.

Post-Service Claim for Benefits Inquiry
A Post-Service Claim for Benefits Inquiry is defined as a written request expressing disagreement with a claim that has been processed correctly according to the member's benefit plan that is not conditioned on a member obtaining approval in advance of obtaining the benefit or service. The health care provider has 180 days from the claim processed date to make such an inquiry. BCBSND will respond to these inquiries within 30 calendar days upon receipt of all relevant information. Any inquiry received after 180 days will be returned to the health care provider without review.

The inquiry determination will be provided in writing, by telephone or through the health care provider remittance. Post-Service Claim for Benefits inquiries will include claim adjustments.

Appeal

An Appeal is defined as a health care provider expressing disagreement with an inquiry determination. There are Pre-Service Claim for Benefits Appeals, Retrospective Review Claim for Benefits Appeals and Post-Service Claim for Benefits Appeals.

Pre-Service and Retrospective Review Appeals can be either verbal or written; however, Post-Service Appeals must be written. Oral inquiries seeking to appeal an action will be treated as an appeal and must be followed by a written, signed appeal unless the Member is requesting an expedited appeal. Oral Pre-Service Claim for Benefits Standard Appeals must be followed with a written, signed appeal.

Pre-Service Claim for Benefits Appeals occur before the service in question is rendered. The Pre-Service Claim for Benefits Appeals are further categorized as Standard and Emergency. Retrospective Review Claim for Benefits Appeals and Post-Service Claim for Benefits Appeals occur after the service has been rendered. The table below identifies the types of Appeals and time frames that apply to each.

Type of Appeal	Time Frame for BCBSND to Respond
Pre-Service Claim for Benefits*	Written response within 30 calendar days
Emergency Claim for Benefits*	Verbal response within 72 hours, followed by a written response within 3 calendar days
Retrospective Review Claim for Benefits*	Written response within 30 calendar days
Post-Service Claim for Benefits*	Written response within 45 calendar days

*See definitions under Inquiry.

Appeal Process

With the Member's written consent, a health care provider may submit written comments, documents and records, or other documents relating to the case to appeal an inquiry determination. The appeal must be received within 90 days from the date BCBSND notifies the health care provider of the inquiry determination. The health care provider must specifically state the nature of the appeal and include all supporting information and rationale for overturning the inquiry determination. Any Appeal received after 90 days will be returned to the health care provider without review. All appeals will be acknowledged upon receipt

The period for resolving standard appeals may be extended by up to 14 calendar days if the Member requests the extension or if BCBSND demonstrates there is a need for additional information and that the delay is in the best interest of the Member. The Member will be notified in writing regarding the reason for an extension that was not requested by the Member.

BCBSND will take all the information into account during the Appeal process without regard to whether the information was submitted or considered in the initial consideration of the case.

A BCBSND Medical Director/Medical Consultant who was not involved in the original inquiry determination will review the appeal. This individual will be board certified in the same or similar specialty as the provider who typically manages the medical condition appealed and is not the individual who made the original non-certification, or the subordinate of such an individual.

BCBSND will implement the decision of the appeal promptly and as expeditiously as the Member's health condition requires if the initial denial is overturned and respond with a written notice of the final determination within the time frames shown above. Emergent Pre-Service Appeal response will be communicated via telephone and writing.

BCBSND must pay for the disputed services the Member received while the appeal was pending if the initial denial is overturned.

Expedited Appeal Procedure
The Member or his or her representative may submit an expedited appeal orally or in writing. An expedited appeal is only appropriate when BCBSND or the provider indicates that taking the time for a standard appeal resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.

BCBSND will not take punitive action against a provider who requests an expedited resolution or supports a Member's appeal.

If BCBSND denies a request for expedited resolution of an appeal, the appeal will be transferred to the standard time frame for resolution. The Member will receive prompt oral notification that the appeal is not considered expedited. Oral notice will be followed by written notice within 2 calendar days.

The period for resolving expedited appeals may be extended by up to 14 calendar days if the Member requests the extension or if BCBSND demonstrates there is a need for additional information and that the delay is in the best interest of the Member. The Member will be notified in writing regarding the reason for an extension that was not requested by the Member.

Continuation or Reinstatement of Benefits
BCBSND will continue the Member's benefits previously authorized while the appeal and/or the State Fair Hearing are pending if:

- The Member requests an extension of benefits, and
- The appeal is filed timely; and
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment, and
- The services were ordered by an authorized provider, and
- The original period covered by the original authorization has not expired.

If BCBSND continues or reinstates the benefits while the appeal and/or State Fair Hearing is pending, the services must continue until one of the following occurs:

- The Member withdraws the appeal.
- **10 calendar** days pass after BCBSND mails the notice of the adverse determination, unless the Member has requested continuation of benefits pending a State Fair Hearing decision.

- The State Fair Hearing office issues a hearing decision adverse to the Member.
- The Time period or benefit limit of the previously authorized service has been met.

BCBSND may recover the cost of the services provided to the Member while the appeal is pending if the final resolution of the appeal is adverse to the Member,

State Fair Hearing
If a Member is not satisfied with the appeal decision, they have up to 30 days from the date of their appeal letter to appeal the decision to the North Dakota Department of Human Services.

Time Frames for mailing written notifications

- Within 14 calendar days of the request for a Standard Pre-Service Claim for Benefits inquiry.
- Within 3 calendar days for Emergency Pre-Service Claim for Benefits inquiry.
- At least 10 days before the date of action to terminate, suspend, or reduce previously authorized services, except:
    a. The period of advanced notice is shortened to five calendar days if probable recipient fraud has been verified.
    b. By the date of action for the following:
        i. In the death of the Member;
        ii. Receipt of a signed written statement by the Member requesting the termination of services or gives information that requires the termination or reduction of services;
        iii. The Member has been admitted to a facility where they are ineligible for further services under the Benefit Plan;
        iv. The Member's address is unknown and mail directed to the Member has no forwarding address;
        v. The Member's health care provider prescribes a change in the level of medical care.
        vi. The Member has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth.
        vii. The date of action will occur in less than 10 days.

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Grievance Process
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or
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Grievances may be filed orally or in writing no later than 90 calendar days after the incident. All Grievances will be acknowledged upon receipt. The Member or Member's Parent will receive a response within 30 days.

Access and Availability of Providers

BCBSND members shall have adequate access and availability to Primary Care and Specialty Care Providers to meet their needs including emergency services.

BCBSND has established standards to ensure that all covered services, including additional or supplemental services contracted for or on behalf of the Member, are available and accessible 24 hours a day, 7 days a week, when medically necessary. BCBSND will ensure that provider after hours answering machines instruct members to go to an emergency room or call 911 in the event of an emergency.

BCBSND will follow the recommended benchmarks for appointment availability:

Timeliness:

Primary Care Providers	
Type	**Days**
Routine, Non-Urgent Appointments	Within 21 Calendar Days
School Physicals	Within 60 Calendar Days
Urgent, Symptomatic but non-life threatening	Within 2 Calendar Days

Specialist	
Type	**Days**
Non-Urgent Appointments	Within 30 Calendar Days
Urgent, Symptomatic but non-life threatening	Within 2 Calendar Days