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Provider Inquiry and Appeal Process

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This document identifies the inquiry and appeals 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 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 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 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.