



Provider Internal Post-Service Claim Appeal Process Q&A*

**Not applicable to pre-determinations, provider audits, or appeals regarding termination from network. Does not apply to Blue Advantage.*

What is an appeal?

An appeal is when a provider formally requests (via appeal form or letter) a reconsideration of a previously adjudicated claim which may or may not include additional information.

Examples of appeals include, but are not limited to:

- Payer allowance
- Medical necessity (including cosmetic and investigational)
- Incorrect payment/coding rules applied
- Errors in administration of coordination of benefits (COB), coinsurance/deductibles, coverage/benefits, eligibility, timely filing

Following are examples of what is not considered a provider appeal:

- Corrected claim
- Provider complaints regarding medical policy
- Contracting issues
- General inquiries/questions
 - Provider request to “review” a claim
 - Pricing issue not associated with a post-service claim
 - Scope of Practice
- Any claim denied needing additional information
 - Unsolicited medical records
- Provider appeal on behalf of member (see member appeal process)
- Notes written on copies of claim forms or provider remittances without supporting documentation

When can I request an appeal?

Blue Cross will perform a single internal appeal as a courtesy to the provider when there is an adverse benefit determination as described above. Providers should also refer to their Participating or Preferred Agreement for dispute resolution options.

How do I request an appeal?

Providers should submit a formal request via the appeal form that has been developed for use by providers. The form can be found at: www.bcbsal.com/providers. A letter may also be submitted that contains: the reason for the appeal; the patient’s name; the patient’s contract number; sufficient

information to reasonably identify the claim or claims being appealed, such as date of service, provider name, procedure, and claim number; and a statement that the request is for an appeal. **Please be sure to include any supporting information or explanation, including any relevant procedural notes, chart notes and/or medical records as appropriate to the review.**

Where do I send my appeal request?

All appeal correspondence should be submitted to the following:

BCBS of Alabama Appeals
Post Office Box 10408
Birmingham, AL 35202-0408
FAX 205-220-9562

What if I disagree with an initial appeal determination?

If the provider has completed the initial internal appeal, any subsequent appeal rights will be defined by their Participating or Preferred Provider Agreement or legal settlement then in effect with the provider.

Physicians participating in the Love Settlement Agreement may qualify for an external review process after exhaustion of the Blue Cross initial internal appeal process. *Note: Love Settlement guidelines do not apply to Blue Advantage patients.*

Physician External Review Process

Independent Medical Expert Consulting Services, Inc. (IMEDECS) has been selected as the Billing Dispute Resolution Reviewer and Independent Review Organization for Medical Necessity Disputes under the terms of the Love Settlement agreement.

Physician Billing Disputes: This review process seeks to resolve disputes concerning application of coding and payment rules and methodologies for fee-for-service claims to patient specific factual situations. This includes bundling, downcoding, application of a CPT modifier, and/or other reassignment of a code. **An individual medical doctor or medical doctor group must exhaust the initial internal**



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appeal process described above and the dispute must exceed \$500 to qualify for the external billing dispute process. The physician or physician group may submit a billing dispute with an amount in dispute less than \$500 if IMEDECS is notified that additional billing disputes during the one-year period following the submission of the original billing dispute with similar issues are forthcoming. IMEDECS will defer consideration of the dispute while the physician accumulates additional similar disputes. A filing fee, dependent on the amount in dispute, must also be submitted with the request.

Physician Medical Necessity Disputes: This review process seeks to resolve disputes concerning services that are determined to be non-covered due to not being medically necessary or are experimental or investigational in nature.

The physician must exhaust the post-service internal appeal process to qualify for the external review process.

The physician may submit a written request to IMEDECS within sixty (60) days from the date of the internal post-service appeal non-coverage decision. Physicians seeking external review shall pay a filing fee of fifty dollars (\$50) if the amount in dispute is \$1,000 or less or \$250 if the amount in dispute exceeds \$1,000. Payment must be submitted with the review request.

IMEDECS

Attn: Jimilou Budusky
157 S. Broad Street
Lansdale, PA 19446

Main: 1-215-855-4633, ext. 324

Fax: 1-215-855-5318

For further information regarding the external review process and applicable filing fees, please click the following link:

<http://www.bcbsal.org/providers/phyBillingDisputes.cfm>