Policy Name: New and Existing Medical Technology  
Policy Number: Utilization Management - 1  
Effective Date: 1/1/01  
Revision Date: Review Date: 2/1/10  

Approval Signature:  
Senior Medical Director  
HMOI, BA HMO, BlueChoice Select, PPO  
Approved QI: 2/3/10  
Approved P&P: 1/14/10  

Policy:

Health Care Service Corporation (HCSC) evaluates the status of existing and emerging medical technologies, behavioral health procedures, pharmaceuticals and devices for inclusion in benefit certificates. HCSC maintains a Corporate Medical Policy Manual that includes policies reflecting the current assessment of existing and new medical and behavioral health procedures, pharmaceuticals and devices. The Managed Care Products use the Medical Policies as a guideline in conjunction with the member benefit certificates to make coverage determinations.

Purpose/Objectives:

• To establish a formal mechanism to evaluate and address new developments in technology and new applications of existing technologies for inclusion in the benefit certificates.
• To keep pace with changes in medical and behavioral technologies.
• To ensure that members have access to safe and effective care.

Guidelines:

A. The development of HCSC new medical policies or position statements, as well as the periodic review of existing medical policies and position statements, is based on research that may include:

1. Assessments published by national technology assessment organizations, including the Blue Cross Association’s Technology Evaluation Center, and other organizations that have national physician participation and provide technology assessments;
2. Assessments published in peer reviewed medical literature;
3. Technology review publications from specialty societies;
4. Approval statements from the Food and Drug Administration and other government regulatory agencies concerning new drugs and devices;
5. Legislative mandates directing coverage for specific medical services;
6. Assessments of new behavioral health procedures obtained from the delegated entity managing behavioral health services for Blue Cross and Blue Shield of Illinois (BCBSIL) members.
**Procedure:**

A. Technology Evaluation Process
   1. Existing and emerging technology is assessed against five key criteria:
      - The technology must have final approval from the appropriate governmental regulatory bodies.
      - The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes.
      - The technology must improve the net health outcomes.
      - The technology must be as beneficial as any established alternatives.
      - The improvement must be attainable outside of the investigational settings.

B. Medical Policy and Position Statement Development
   1. The HCSC Medical Policy Development Workgroup reviews currently published information about the medical or behavioral health technology, pharmaceutical or device to develop a draft medical policy or position statement.
   2. The Enterprise Review Workgroup, comprised of BCBSIL physicians, relevant physician or professional specialists and network physicians, evaluates the draft medical policy or position statement and makes recommendations to the Medical Policy Development Workgroup.
   3. The draft policy is presented for approval to the Corporate Consistency Oversight Board (CCOB). Medical policies are considered to be final and in force when approved by CCOB.
   4. The medical policies approved by CCOB are then provided to the Implementation Committee for inclusion in the Corporate Medical Policy Manual.
   5. Periodically, the effectiveness of the medical policy is evaluated through oversight and reporting.
   6. Active medical policies are re-reviewed based on a defined cycle and as new information becomes available.

C. When an inquiry is received by medical support or medical management concerning new and/or existing medical technology:
   1. The Medical Director will review the relevant HCSC Corporate Medical Policy.
   2. The Medical Director will respond to the inquiry based on the available clinical information, the member benefit certificate, and related medical policies.
   3. BCBSIL will communicate the determination to the initial inquirer.
Policy:

Blue Cross and Blue Shield of Illinois (BCBSIL) utilizes a Pharmacy Benefits Management (PBM) vendor and the Pharmacy and Therapeutics (P&T) Committee of the PBM to develop, maintain and promote a formulary system based on safety, efficacy and cost of pharmaceutical care.

BCBSIL members have access to an open formulary for prescription medications. Payments for formulary medications are subject to varying co-payments for generic, formulary brand and non-formulary brand drugs.

Purpose:

- To ensure the prescription drug formulary system is based on safety, efficacy and cost of pharmaceutical care.
- To create value for both providers and members by developing and maintaining a select list of products that benefits both patient care and program costs.
- To review, update and distribute pharmaceutical management procedures annually and when changes are made.

Guidelines:

1. The National P&T Committee will:
   - Develop policies regarding the evaluation, selection and therapeutic use of pharmaceuticals.
   - Evaluate and select pharmaceutical products for formulary inclusion based on established criteria.
   - Review new entities that represent significant therapeutic advances with development of guidelines for use, when appropriate, within six months of Federal Drug Administration (FDA) approval.
   - Review agents and major therapeutic classes in a timely manner. Re-evaluate agents and therapeutic classes when new developments occur.
   - Promote the use of FDA approved “A” rated generic drugs as appropriate, including consideration of “critical” drugs (i.e., those drugs with a narrow therapeutic index where generic substitution may not be in the best interests of the patient).
   - Provide recommendations or assistance in the development of appropriate-use programs designed to meet the needs of all managed care professionals.
Pharmaceutical Management
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- Serve in an evaluative, educational, and advisory capacity to BCBSIL in matters pertaining to drug therapy management.
- Develop, review and update the Prescription Drug Formulary as new pharmaceutical information becomes available.
- Review the results of drug use evaluation and drug utilization review programs and make recommendations to optimize appropriate drug use.
- Disseminate information, actions and approved recommendations to committee members, PBM clients, providers and others as appropriate.

Procedure:

I. P&T Committee Organization and Operation
   A. The P&T committee will be composed of at least the following members:
      1. Physicians
      2. Pharmacists
      3. Pharmacologists
      4. Other healthcare professionals
   B. An independent physician will serve as Chairperson.
   C. The committee meets a minimum of once a quarter.
   D. The minutes of the committee meetings will be prepared by the secretary and maintained in the permanent records at the PBM.
   E. The actions of the committee will be communicated to all appropriate health-care personnel.
   F. The committee will be organized and operated in a manner that ensures the objectivity and credibility of its recommendations.
   G. The committee will establish and enforce a conflict of interest policy and confidentiality policy with respect to committee recommendations and actions.

II. The committee maintains the following guidelines and policies:
   A. Basis of Recommendations:
      1. Drugs will be reviewed for clinical efficacy and safety. Other factors which may impact the therapeutic value of a drug are considered. Those factors include but are not limited to:
         a) Convenience and ease of administration
         b) Relevant clinical guidelines or treatment protocols
         c) Utilization patterns
         d) Medical need
         e) AWP costs (Average Wholesale Price)
   B. Voting Process
      1. If any committee member determines there is a conflict of interest regarding the vote for a particular agent, the member must voice a disclaimer before the discussion begins and abstain from the voting process if deemed necessary.
      2. A quorum of two-thirds of the voting members of the PBM P&T Committee is needed to vote on decisions.
      3. A decision may be revisited at the discretion of the PBM P&T Committee.
III. Criteria for Drug and Therapeutic Class Review:
   A. Request of PBM P&T Committee member, client or network physician.
   B. An individual member or provider may request PBM P&T Committee action on a particular drug or therapeutic class of drug by contacting their health plan or employee benefit administrator. The health plan or employer will communicate the request directly to the PBM.
   C. New drug entity - preference will be given to drugs reviewed by the FDA on a priority basis.
   D. Any currently marketed drug that has not been previously reviewed or has received a new indication.
   E. Must have a published average wholesale price (individual drug).

IV. Pharmaceutical Patient Safety Issues
   A. The PBM maintains a system to identify, classify and notify pharmacists, providers and members at the point of dispensing of the following:
      1. Drug to drug interactions for identified severity levels.
      2. Specific drug to drug interactions when they meet the identified severity levels.
   B. The PBM maintains a system to identify and notify members and prescribing practitioners affected by:
      1. FDA class I recall which must include an expedited process for prompt identification and notification of members and prescribing practitioners.
         a) The PBM will notify members and prescribing physicians with a notification letter within 7 business days of the Class I recall.
         b) The PBM will also contact the client regarding the recall.
         c) The notification process will begin within 1-2 business days of FDA notification to the PBM.
      2. FDA Class II recall or voluntary drug withdrawals from the market within 30 calendar days of the FDA notification.
   C. The PBM notifies physicians of drug recalls through the mailing of a Drug Safety Alert. The notification includes a list of their patients who recently filled a prescription for the medication.

V. Pharmaceutical Restrictions and Preferences
   A. BCBSIL maintains an open Prescription Drug Formulary.
      1. All prescription medications are covered at varying co-payments.
         a) Therapeutic substitution is a voluntary program that requires consent of the prescribing physician and the member at the point of dispensing.
         b) Generic substitution is encouraged but is not mandatory. Generic products are covered at a lower co-payment than the brand equivalent.
         c) Prior authorization is required on select medication categories including: hepatitis C treatment, growth hormones, anabolic steroids, and oral fentanyl products, narcolepsy agents and Solodyn.
         d) Step therapy is required on select medication categories including: cholesterol, gastroesophageal reflux disease/ulcer, hypertension, insomnia, osteoporosis and rheumatoid arthritis/psoriasis.
2. Prescriptions are covered up to a 34 day supply for one co-payment. Exceptions to this limit are allowed for the following reasons:
   
a) Change of dosage requiring a larger quantity.
b) Medication lost.
c) Vacation supply.
d) Delay in mail-order processing.

3. BCBSIL provides a copy of the formulary and pharmaceutical management procedures to contracted practitioners and medical groups for distribution to their practitioners annually, and when changes are made.

4. All changes to the formulary are communicated to practitioners via the provider newsletter. Changes to the pharmaceutical management procedures are communicated via BlueReview and BCBSIL’s Web site, www.bcbsil.com.

5. A current version of the formulary is maintained and available to practitioners and members on BCBSIL’s Web site, www.bcbsil.com.
Policy:

Blue Cross and Blue Shield of Illinois (BCBSIL) will review all HMO, BlueChoice, BlueChoice Select and PPO member clinical appeals in a thorough, appropriate and timely manner.

Purpose:

- To ensure thorough, timely and appropriate handling of member appeals.

Guidelines:

- A Member, his/her authorized representative, physician, facility, or other health care provider may request an appeal on behalf of the member.
- If a member selects an authorized representative to act on his/her behalf, written authorization from the member is required at the time of the request.
- All clinical appeals are reviewed by a board-certified clinical peer, in a same or similar specialty that typically manages the condition or care in question, who was not involved in the original decision and not a subordinate of the original decision-maker.
- The decision of the clinical peer is binding.
- The Member may appeal to the Illinois Department of Insurance at any time.
- All HMO and POS Members may request an external independent review of the appeal at any time.
- The appeal process does not imply that BCBSIL is required to pay for health care services not covered under the Member’s benefit plan document.
- BCBSIL will accept all member appeals regardless of the 180 day submission timeframe required by law.

Definitions:

1. **Clinical Appeal** - an appeal regarding denial of a service that is a covered benefit in the benefit plan document, or could be considered to be a covered benefit depending upon the circumstances, when the basis for the appeal is clinical in nature. Examples of clinical appeals include:
   - Appeals involving services denied on the basis of lack of medical necessity.
   - Appeals regarding an experimental or investigational service when the basis for the appeal is that the practitioner feels the service is not experimental or investigational.
   - Appeals regarding a cosmetic procedure when the basis for the appeal is that the service is needed for medical rather than cosmetic reasons.
• Appeals for access to an out-of-network practitioner or provider when the basis for the appeal is that access to a practitioner or provider with appropriate clinical expertise has not been provided.

Note: Appeals are not considered to be clinical appeals when there is no clinical basis for the appeal, and/or when a service is explicitly excluded in the benefit plan document. Examples of appeals that are not clinical appeals include:

• Appeals for additional services beyond the limited number provided in the Certificate (i.e. outpatient rehabilitation therapy, inpatient and outpatient mental health).
• Appeals for coverage of Investigational services when there is no dispute that the service is Investigational.
• Appeals regarding coverage of cosmetic procedures when there is no dispute that the procedure is cosmetic in nature.
• Appeals regarding referral to an out-of-network practitioner when the basis of the appeal is a Member convenience or a previous relationship with the practitioner.
• Appeals for coverage of services explicitly excluded from coverage in the benefit plan document.

2. **Pre-service Appeal** – a request to change an adverse determination for care or services that must be approved in whole or in part in advance of the member obtaining care or services.

3. **Post-service Appeal** – a request to change an adverse determination for care or services that have already been received by the member.

4. **Expedited Appeal** – a pre-service or concurrent request to change an adverse determination for urgent care.

5. **Urgent care** - a request for medical care or treatment with respect to which the application of the time-periods for making non-urgent care determinations:
   → could seriously jeopardize the life or health of the member, or the member’s ability to regain maximum function, based on a prudent layperson’s judgment, or
   → in the opinion of the practitioner with knowledge of the member’s medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

6. **Non-Urgent Appeal** – a pre-service or post-service appeal that does not meet the urgent care expedited appeal criteria.

7. **Clinical Peer** - a health care professional who:
   → is in the same profession and the same or similar specialty as the health care provider who typically manages the medical condition, procedures, or treatment under review,
   → holds a current active, unrestricted license to practice medicine or a health profession,
   → is board certified by a specialty board approved by the American Board of Medical Specialties (doctors of medicine); or the Advisory Board of Osteopathic Specialists from the major areas of clinical services (doctors of osteopathic medicine); (Note: Board certification requirement is not applicable to provider types other than doctors of medicine and doctors of osteopathic medicine.)
8. **Health Care Services** - Any service included in the provision of medical care, as outlined in the Member's benefit plan documents, for the purpose of preventing, alleviating, curing or healing human illness or injury.

**Procedure:**

**Urgent Care / Expedited Pre-service and Concurrent Appeals:**

1. Timeframe for completion of urgent care / expedited pre-service and concurrent appeal requests is no later than 72 hours from receipt of the request to notification of the decision. The review must occur as expeditiously as the medical condition requires.

2. Following receipt of a verbal or written urgent care / expedited pre-service or concurrent appeal request, the designated appeal staff will review all information received.

3. If additional information is needed from a contracted HMO IPA or PCP to evaluate the member’s appeal, the IPA has 24 hours to respond with the required information. If no response is received within 24 hours, one HMO administered complaint will be assigned along with an urgent request for a response within two hours.

4. If the request is related to a case under review by the Medical Management department, the Medical Management department clinical documentation system is reviewed for additional information.

5. The member may submit any additional comments, documents or other information related to the appeal.

6. All information is evaluated by the designated appeal physician immediately.
   a) If the designated appeal physician overturns the original denial:
      b) Verbal notification of the decision to the member or member representative, physician and facility, if applicable, is provided within 72 hours of request. Written notification is completed within the following three calendar days of verbal notification and includes all elements referenced in #7, below. (See Attachments)
         • The appropriate database and Inquiry Reporting System are updated and the complete file is maintained in a secure area including but not limited to a locked cabinet and/or BCBSIL corporate electronic record storage system.
   c) The designated appeal physician does not overturn the original denial during evaluation:
      • Appeal file is immediately forwarded to an internal or external clinical peer for review, as indicated by the designated appeal physician’s documentation.
      • If an internal clinical peer is available, note the clinical peer identified to review the appeal.
      • If an external clinical peer is required:
         → Complete the Peer Service Request Form indicating the specialty required and that the decision is needed within 24 business hours.
         → The pertinent medical information is sent via fax with the request.
7. Upon receipt of the clinical peer decision, verbal notification of the decision to the member or member representative, physician and facility, if applicable, within 72 hours of receipt of the appeal request. The written notification will be completed within the following three calendar days, and will include:

- The appeal determination,
- The principal reason for the determination,
- A reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based,
- The clinical rationale, which includes an understandable summary of the medical criteria, benefit provision, guideline or protocol used to make the determination,
- A statement that the specific medical criteria or benefit provision used in making the determination will be provided upon request,
- The titles and qualifications of the individual(s) participating in the appeal review,
- A statement that copies of all documents relevant to the member’s appeal will be provided upon request.
- If the appeal decision maintains the original adverse decision and the appeal request is from an HMO or BlueChoice member, the written notification will also include:
  → a description of the procedure for requesting an external independent review,
  → the timeframe for submission of an external appeal request,
  → the member's right to designate someone to act on his/her behalf,
  → language confirming the external reviewer’s decision is binding,
  → a statement that benefits beyond those included in the benefit certificate are not eligible for external review and
  → a statement that there is no cost to the member should they request external review.
  → a description of further appeal rights if applicable.

(See Attachments)

8. The appropriate database is updated and the complete file is maintained in a secure area including but not limited to a locked cabinet and/or BCBSIL corporate electronic record storage system.

Non-urgent Pre-service and Post-service Appeals

1. Timeframe for completion of non-urgent post-service clinical appeal requests is 30 calendar days from receipt of the request and pre-service requests is 15 calendar days from the receipt of the request to notification of the decision.

2. Following receipt of a verbal or written non-urgent pre-service or post-service clinical appeal request, the designated appeal staff will review all information received.

3. If additional information is needed from a contracted HMO IPA (Independent Physician Association) or PCP (Primary Care Physician) to evaluate the member’s appeal, the IPA
4. has five calendar days to respond with the required information. If no response is received, one HMO administered complaints will be issued.

5. If the request is related to a case under review by the Medical Management department, the Medical Management department documentation system is reviewed for additional information.

6. The member may submit any additional comments, documents or other information related to the appeal.

7. Complete files are evaluated by the designated appeal physician.
   a) The designated appeal physician overturns the original denial:
   b) Verbal and written notification of the decision to the member, physician and facility, if applicable, is provided. (See Attachments)
      - The appropriate database and Inquiry Reporting System are updated and the complete file is maintained in a secure area including but not limited to a locked cabinet and/or BCBSIL corporate electronic record storage system.
      - The designated appeal physician does not overturn the original denial during evaluation:
        a) Appeal file is forwarded to an internal or external clinical peer for review, as indicated by the designated appeal physician's documentation.
        - If the designated appeal physician’s documentation indicates an internal clinical peer is available, note the clinical peer identified to review the appeal.
        - If an external clinical peer is required:
          → Complete the Peer Service Request Form indicating the specialty required and the timeframe for completion.
          → The pertinent medical information is sent to the external clinical peer via fax and overnight mail.

8. Upon receipt of the clinical peer decision, written notification of decision to the member, physician and facility, if applicable, will be sent which will include:
   - The appeal determination,
   - The principal reason for the determination,
   - A reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based,
   - The clinical rationale, which includes an understandable summary of the medical criteria, benefit provision, guideline or protocol used to make the determination,
   - A statement that the specific medical criteria or benefit provision used in making the determination will be provided upon request,
   - The titles and qualifications of the individual(s) participating in the appeal review,
   - A statement that copies of all documents relevant to the member’s appeal will be provided upon request.
• If the appeal decision maintains the original adverse decision, and the appeal request is from an HMO or BlueChoice member, the written notification will also include:
  → a description of the procedure for requesting an external independent review,
  → the timeframe for submission of an external appeal request,
  → the member's right to designate someone to act on his/her behalf,
  → language confirming the external reviewer's decision is binding,
  → a statement that benefits beyond those included in the benefit certificate are not eligible for external review and
  → a statement that there is no cost to the member should they request external review.
  → a description of further appeal rights if applicable.
  (See Attachment)

9. The appropriate databases and Inquiry Reporting System are updated and the complete file is maintained in a secure area including but not limited to a locked cabinet and/or BCBSIL corporate electronic record storage system.

**External Independent Review**
Applies to HMO and POS Members Only.

Following an adverse determination for a pre-service, concurrent or post-service clinical appeal, HMO and BlueChoice members may request an external independent review. The Member may request an external independent review directly from an Independent Review Organization, (IRO).

**Standard Process**

1. A written request for an external independent appeal review from an HMO or POS member must be received within 30 calendar days of receipt of an adverse appeal determination.

2. The timeframe for completion is 30 calendar days from receipt of the request to notification of the decision.

3. Upon receipt of a member’s written request for external independent review, the designated appeal staff will:
   • Select an external independent reviewer that is acceptable to the Member, and/or the Member’s physician or other health care provider;
   • Submit all relevant records and documentation to the independent reviewer. This information includes pertinent medical records, case summary, criteria used, benefits information and the medical and clinical reasons for the decision.

4. Payment for services of the independent reviewer will be solely the responsibility of BCBSIL.

5. The independent reviewer will:
   • be a Clinical Peer,
6. The designated appeal staff will inform the Member in writing of the IRO decision. In the event the independent review organization overturns the appeal decision, the designated appeal staff will inform the Member in writing of the time and procedure for claim payment or approval of service. (See Attachments) Member appeals are tracked, trended and reported to the Managed Care QI Committee.

7. The appropriate databases and Inquiry Reporting System are updated and the complete file is maintained in a secure area including but not limited to a locked cabinet and/or BCBSIL corporate electronic record storage system.

**Expedited Process**

1. Expedited External Independent Appeal reviews can only be initiated if a clinical denial of a pre-service or concurrent review:
   → could seriously jeopardize the life or health of the member, or the member’s ability to regain maximum function, based on a prudent layperson’s judgment, or
   → in the opinion of the practitioner with knowledge of the member’s medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

2. If the external independent appeal review request is from an HMO member and additional information is required from the IPA to initiate the expedited appeal, the IPA has 24 hours to respond to the HMO’s request. If no response is received within 24 hours, three HMO administered complaints will be assigned along with an urgent request for a response within 2 hours.

3. A final determination by the independent reviewer will be made within 24 hours. These reviews will be handled as expeditiously as possible.

4. Within 72 hours of the request, the designated appeal staff will inform the Member by telephone of the IRO decision. Written notification will be completed within three calendar days. In the event the independent review organization overturns the appeal decision, the designated appeal staff will inform the Member in writing of the time and procedure for claim payment or approval of service. (See Attachments)

5. Member appeals are tracked, trended and reported to the Managed Care QI Committee.

6. The appropriate databases and Inquiry Reporting System are updated and the complete file is maintained in a secure area including but not limited to a locked cabinet and/or BCBSIL corporate electronic record storage system.

**Documentation**

*BCBSIL maintains records for each appeal that includes:*

a) **The name of the patient, provider, and/or facility**

b) **Copies of all correspondence from the patient, provider or facility rendering service and BCBSIL regarding the appeal**

c) **Dates of appeal reviews, documentation of actions taken and final resolution**

d) **Name and credentials of the clinical peer reviewer**
Member Urgent/ Expedited Clinical Appeal
All Products

Phone call, fax or written correspondence initiating the appeal →
Review information received and Clinical documentation system information

Is information complete? →
Yes

Appeal Physician evaluates info immediately

Appeal file is forwarded for clinical peer specialty matching immediately

Clinical peer/ specialty matching occurs within 1 business day

End Process

Verbal notification with 72 hours of initial request, Written notification sent to all parties within the following three calendar days.

Yes

Verbal notification with 72 hours of initial request, Written notification sent to all parties within the following three calendar days.

Is information received within 72 hours? →
Yes

Appeal Physician overturns denial?

No

Determination is made based on available info

Clinical documentation system, Appeal database and Inquiry Reporting System updated

End Process

Reviewed 4/1/10

TIMEFRAME: 72 hours from receipt of appeal request to notification of decision.
Member Non-Urgent Clinical Appeal
All Products

Phone call, fax or written correspondence initiating the appeal

File to appeal PA for evaluation.

PA makes appeal decision.

Can PA Approve?

Yes

Is PA a specialty match?

Yes

Send written notification to appropriate parties.

Case routed to alternate in-house PA for review and decision

No

No

Document decision in appropriate databases and Inquiry Reporting System.

End process.

Is there another in-house PA specialty match?

Yes

Appeal staff prepares and sends file to consultantMRO for clinical peer specialty match review

No

Decision received and accepted.

Reviewed 4/1/10

TIMEFRAME:
30 calendar days from receipt of request to notification of appeal decision
HMO/POS CLINICAL APPEAL DENIAL LETTER WITH IRO INFORMATION

(insert date)

(insert name)
(insert address)
(insert city, state and zip)

Subscriber:
Member:
Group/ID#:

Dear (insert name):

This letter is in response to your request for an Appeal of the denial of benefits for services from (insert denial information) for the above named member. A physician who specializes in (insert physician type), who had no involvement in the original denial, reviewed your request along with the available clinical information and has rendered the following determination:

(Insert appeal decision and specific reason for the appeal decision, including the specific benefit provision, guideline, protocol or other criterion on which the decision was based.)

Upon request, the physician, facility, health care provider, member or member representative may have access to a copy of the clinical rationale, medical criteria or benefit provision used to make the determination, as well as copies of documents relevant to the appeal.

(change language if inquirer is not the member)

You may request that this appeal be forwarded for consideration by an external independent reviewer. This request must be in writing and submitted within 30 calendar days of receipt of this letter. Upon our receipt of your written request,

• An external independent reviewer will be selected that is mutually acceptable to the health plan, the member and the involved practitioner.

• All relevant records and documentation will be submitted to the external independent reviewer. This information includes pertinent medical records, case summary, criteria used and the medical and clinical reasons for the decision. The member may request access to the clinical documentation reviewed to render the determination by writing or calling the address listed below.

• Upon receipt of all relevant and/or requested documentation, the external independent reviewer then determines if the request meets the eligibility requirements for review in order to proceed.

If you choose this option, the written request should be forwarded to:

(Insert Staff Person’s Name Here)
Blue Cross Blue Shield of Illinois
Consumer Services Management, 24th Floor
300 E. Randolph St.,
Chicago, Illinois 60601-5099

Or for your convenience, faxed to 312-616-1584.

Please be advised that payment of the services of the external independent reviewer will be solely the responsibility of Blue Cross and Blue Shield of Illinois. The independent reviewer will be a clinical peer of a same or similar specialty as the involved practitioner and will not have a financial interest in this case.
HMO/POS CLINICAL APPEAL DENIAL LETTER WITH IRO INFORMATION

Some of the operations of Blue Cross Blue Shield of Illinois are regulated by the Illinois Department of Insurance. If you wish to take up this matter with Illinois Department of Insurance, it maintains a Consumer Division in Chicago at 100 W. Randolph Street, Suite 15-100, Chicago, Illinois 60601-1115 and in Springfield at 320 W. Washington Street, Springfield, Illinois 62767-0001. The Illinois Department of Insurance, Consumer Division, can be contacted by telephone toll free at 1-877-527-9431.

In addition, you have the right to bring a civil action under section 502(a) of ERISA following an adverse determination of review, provided you are in a group insurance plan that is not a government or church group. (change the language if someone other than the member is the inquirer)

If you have additional questions, please contact me at (insert staff telephone number).

Sincerely,

(insert name)
Insert Title
Appeal Department
Consumer Services Management

Cc: Cathy McClain-Gordon, Senior Director, Consumer Services Management
HMO/POS MEMBER IRO APPROVAL

(insert date)
(insert name)
(insert address)
(insert city, state and zip)

Subscriber:
Member:
Group/ID#:

Dear (insert name):

As you requested, the request for benefit coverage for (insert service requested/received) was forwarded and reviewed by an external independent reviewer.

The external independent physician, who specializes in (insert specialty of the reviewing physician) and is associated with (insert name of IRO), was provided the relative materials including (insert list all documents). Based on this review, the following determination has been made:

(Insert appeal decision and specific reason for the appeal decision, including the specific benefit provision, guideline, protocol or other criterion on which the decision was based) – BE SURE TO INCLUDE ANY AND ALL APPROVAL TIME FRAMES AND/OR LIMITATIONS AS STATED IN THE APPROVAL RECOMMENDATION.

if outstanding claims are present leave this paragraph in, if not omit) Our office has requested the claim(s) for the above referenced date(s) of service be processed and paid in accordance with the member’s Certificate of Health Care Benefits including applicable deductibles, co-insurance, calculation of eligible charges and the institution/provider contract with Blue Cross and Blue Shield of Illinois.

Upon request, the physician, facility, health care provider, member or member representative may have access to a copy of the clinical rationale, medical criteria or benefit provision used to make the determination, as well as copies of documents relevant to the appeal.

Actual availability of benefits is subject to member eligibility and other terms, conditions, limitations and exclusions of the member’s health care benefit plan. For questions regarding health plan benefits available for members, please contact the Customer Service Unit at the telephone number listed on the back of the member’s Blue Cross and Blue Shield I.D. card.

Blue Cross and Blue Shield of Illinois is solely responsible for paying for the services of the external independent reviewer.

Upon request, the physician, facility, health care provider, member or member representative may have access to a copy of the clinical rationale, medical criteria or benefit provision used to make the determination, as well as copies of documents relevant to the appeal.

Actual availability of benefits is subject to member eligibility and other terms, conditions, limitations and exclusions of the member’s health care benefit plan including but not limited to any pre-existing condition waiting period, if any. For questions regarding health plan benefits available for members, please contact the Customer Service Unit at the telephone number listed on the back of the member’s Blue Cross and Blue Shield I.D. card.
HMO/POS MEMBER IRO APPROVAL

Please be advised that payment of the services of the external independent reviewer will be solely the responsibility of Blue Cross and Blue Shield of Illinois. The independent reviewer will be a clinical peer of a same or similar specialty as the involved practitioner and will not have a financial interest in this case.

Some of the operations of Blue Cross Blue Shield of Illinois are regulated by the Illinois Department of Insurance. If you wish to take up this matter with Illinois Department of Insurance, it maintains a Consumer Division in Chicago at 100 W. Randolph Street, Suite 15-100, Chicago, Illinois 60601-1115 and in Springfield at 320 W. Washington Street, Springfield, Illinois 62767-0001. The Illinois Department of Insurance, Consumer Division, can be contacted by telephone toll free at 1-877-527-9431.

If you have additional questions, please contact me at (insert staff member's telephone # here).

Sincerely,

(insert staff name)
Insert Title
Appeal Department
Consumer Services Management

Cc: Cathy McClain-Gordon, Senior Director, Consumer Services Management
(insert date)

(insert name)
(Insert name of provider)
(Insert address)
(Insert city, state and zip)

Subscriber:
Member:
Group/ID#:

Dear (insert name):

As you requested, the request for benefit coverage of (insert service requested/received) was forwarded and reviewed by an external independent reviewer.

The external independent physician who specializes in (insert specialty of the reviewing physician) and is associated with (insert name of IRO) was provided the relative materials including (insert list all documents).

Based on this review the following determination has been made:

(Insert appeal decision and specific reason for the appeal decision, including the specific benefit provision, guideline, protocol or other criterion on which the decision was based.)

The payment of the services of the external independent reviewer is solely the responsibility of Blue Cross and Blue Shield of Illinois.

Upon request, the physician, facility, health care provider, member or member representative may have access to a copy of the clinical rationale, medical criteria or benefit provision used to make the determination, as well as copies of documents relevant to the appeal.

Some of the operations of Blue Cross and Blue Shield of Illinois are regulated by the Illinois Department of Insurance. If you wish to take up this matter with Illinois Department of Insurance, it maintains a Consumer Division in Chicago at 100 W. Randolph Street, Suite 15-100, Chicago, Illinois 60601-1115 and in Springfield at 320 W. Washington Street, Springfield, Illinois 62767-0001. The Illinois Department of Insurance, Consumer Division, can be contacted by telephone toll free at 1-877-527-9431.

In addition, you have the right to bring a civil action under section 502(a) of ERISA following an adverse determination of review, provided you are in a group insurance plan that is not a government or church group.

If you have additional questions, please contact me at (insert staff telephone number).

Sincerely,

(Insert name)
Insert Title
Appeal Department
Consumer Services Management

Cc: Cathy McClain-Gordon, Senior Director, Consumer Services Management
Member Clinical Appeal and External Independent Review
Page 15 of 23

HMO/PPO/POS EXPEDITED CLINICAL APPEAL APPROVAL

(insert date)

(insert name of facility or physician who initiated the appeal)
(insert address)
(insert city, state and zip)

Subscriber:
Member:
Group/ID#:
Treatment Setting:
Date of Admission:
Dates or Services Denied:
Case Number:

Dear (insert name):

This letter is in response to your request for an Expedited Appeal of the denial of benefits for (insert denial information) for the above named member. A physician who specializes in (insert physician type), who had no involvement in the original denial, reviewed your request along with the available clinical information and has rendered the following determination:

(insert appeal decision and specific reason for the appeal decision, including the specific benefit provision, guideline, protocol or other criterion on which the decision was based.) – BE SURE TO INCLUDE ANY AND ALL APPROVAL TIME FRAMES AND/OR LIMITATIONS AS STATED IN THE APPROVAL RECOMMENDATION.

The verbal notification of the findings was provided to (insert name of institution staff determination given to) by telephone (insert date determination given to institution or agency staff).

Our office has requested the claim(s) for the above referenced date(s) of service be processed and paid in accordance with the member’s health care benefit plan, including applicable deductibles, co-insurance, calculation of eligible charges and the institution/provider contract with Blue Cross and Blue Shield of Illinois.

Actual availability of benefits is subject to member eligibility and other terms, conditions, limitations, provider eligibility and exclusions of the member’s health care benefit plan. For questions regarding health plan benefits available for members, please contact the Customer Service Unit at the telephone number listed on the back of the member’s Blue Cross and Blue Shield I.D. card.

Upon request, the physician, facility, health care provider, member or member representative may have access to a copy of the clinical rationale, medical criteria or benefit provision used to make the determination, as well as copies of documents relevant to the appeal.

Please be advised that payment of the services of the external independent reviewer will be solely the responsibility of Blue Cross and Blue Shield of Illinois.

Some of the operations of Blue Cross Blue Shield of Illinois are regulated by the Illinois Department of Insurance. If you wish to take up this matter with Illinois Department of Insurance, it maintains a Consumer Division in Chicago at 100 W. Randolph Street, Suite 15-100, Chicago, Illinois 60601-1115 and in Springfield at 320 W. Washington Street, Springfield, Illinois 62767-0001. The Illinois Department of Insurance, Consumer Division, can be contacted by telephone toll free at 1-877-527-9431.
HMO/PPO/POS EXPEDITED CLINICAL APPEAL APPROVAL

If you have additional questions, please contact me at (insert staff member’s telephone # here).

Sincerely,

Insert name
Insert Title
Appeal Department
Consumer Services Management

Cc: (insert Member name)
   (insert institution name or name of physician)
   Cathy McClain-Gordon, Senior Director, Consumer Services Management
(insert date)

(insert name of facility or physician who initiated the appeal)
(insert address)
(insert city, state and zip)

Subscriber:
Member:
Group/ID#:
Treatment Setting:
Date of Admission:
Dates or Services Denied:
Case Number:

Dear (insert name):

This letter is in response to your request for an Expedited Appeal of the denial of benefits for (insert denial information) for the above named member. A physician who specializes in (insert physician type), who had no involvement in the original denial, reviewed your request along with the available clinical information and has rendered the following determination:

(Insert appeal decision and specific reason for the appeal decision, including the specific benefit provision, guideline, protocol or other criterion on which the decision was based.)

The verbal notification of the findings was provided to (insert name of institution staff determination given to) by telephone (insert date determination given to institution or agency staff).

A Member cannot be billed by Blue Cross and Blue Shield of Illinois contracted PPO/POS facilities for charges associated with an inpatient admission that was not approved by the health plan.

Members may contact the Customer Service Unit listed on the back of their Blue Cross and Blue Shield of Illinois I.D. card for benefit, eligibility, or reimbursement information.

Upon request, the physician, facility, health care provider, member or member representative may have access to a copy of the clinical rationale, medical criteria or benefit provision used to make the determination, as well as copies of documents relevant to the appeal.

Some of the operations of Blue Cross and Blue Shield of Illinois are regulated by the Illinois Department of Insurance. If you wish to take this matter up with the Illinois Department of Insurance, it maintains a Consumer Division in Chicago at 100 W. Randolph Street, Suite 15-100, Chicago, Illinois 60601-1115 and in Springfield at 320 W. Washington Street, Springfield, Illinois 62767-0001. The Illinois Department of Insurance, Consumer Division, can be contacted by telephone toll free at 1-877-527-9431.

In addition, Members may bring a civil action under section 502(a) of ERISA following an adverse determination, provided they are in a group insurance plan that is not a government or church group.
PPO/POS EXPEDITED CLINICAL APPEAL DENIAL LETTER

Sincerely,

Insert Name
Insert Title
Appeal Department
Consumer Services Management

Cc: (insert Member name)
(insert institution name or name of physician)
Cathy McClain-Gordon, Senior Director, Consumer Services Management
HMO/PPO/POS EXPEDITED CLINICAL APPEAL PARTIAL APPROVAL

(insert date)

(insert name of facility or physician who initiated the appeal)
(insert address)
(insert city, state and zip)

Subscriber:
Member:
Group/ID#:
Treatment Setting:
Date of Admission:
Dates or Services Denied:
Case Number:

Dear (insert name):

This letter is in response to your request for an Expedited Appeal of the denial of benefits for (insert appeal request here).

A physician who specializes in (insert specialty type of physician) and who had no involvement in the original denial reviewed your request and the available clinical information. Based on this review the following determination has been made:

(Insert appeal decision and specific reason for the appeal decision, including the specific benefit provision, guideline, protocol or other criterion on which the decision was based.)

BECAUSE THIS IS A PARTIAL APPROVAL, IT IS IMPORTANT TO BE VERY CLEAR ON THE DETERMINATION, DETAILING WHAT THE APPROVAL INVOLVES AND PRECISLEY WHAT IS INCLUDED IN THE DENIAL.

The verbal notification of the findings was provided to (insert name of institution staff determination given to) by telephone (insert date determination given to institution staff).

A Member cannot be billed by Blue Cross and Blue Shield of Illinois PPO/POS contracted facilities for charges associated with an inpatient admission that was not approved by the health plan.

Members may contact the Customer Service Unit listed on the back of their Blue Cross and Blue Shield I.D. card for benefit, eligibility, or reimbursement information.

Upon request, the physician, facility, health care provider, member or member representative may have access to a copy of the clinical rationale, medical criteria or benefit provision used to make the determination, as well as copies of documents relevant to the appeal.

Some of the operations of Blue Cross and Blue Shield of Illinois are regulated by the Illinois Department of Insurance. If you wish to take this matter up with the Illinois Department of Insurance, it maintains a Consumer Division in Chicago at 100 W. Randolph Street, Suite 15-100, Chicago, Illinois 60601-1115 and in Springfield at 320 W. Washington Street, Springfield, Illinois

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HMO/PPO/POS EXPEDITED CLINICAL APPEAL PARTIAL APPROVAL

62767-0001. The Illinois Department of Insurance, Consumer Division, can be contacted by telephone toll free at 1-877-527-9431.

In addition, Members may bring a civil action under section 502(a) of ERISA following an adverse determination, provided they are in a group insurance plan that is not a government or church group.

Sincerely:

Insert Name
Insert Title
Appeal Department
Consumer Services Management

Cc: (insert Member name)
   (insert Institution name or name of Physician)
   Cathy McClain-Gordon, Senior Director, Consumer Services Management
HMO/PPO/POS MEMBER CLINICAL APPEAL APPROVAL LETTER

(insert date)

(insert name)
(insert address)
(insert city, state and zip)

Subscriber:
Member:
Group/ID#:

Dear (insert name):

This letter is in response to your request for an Appeal of the denial of benefits for (insert appeal request here). A physician who specializes in (insert specialty type), who had no involvement in the original denial, reviewed your request and the available clinical information. Based on this review, the following determination has been made:

(Insert appeal decision and specific reason for the appeal decision, including the specific benefit provision, guideline, protocol or other criterion on which the decision was based) – BE SURE TO INCLUDE ANY AND ALL APPROVAL TIME FRAMES AND/OR LIMITATIONS AS STATED IN THE APPROVAL RECOMMENDATION.

(If outstanding claims are present leave this paragraph in, if not omit) Our office has requested the claim(s) for the above referenced date(s) of service be processed and paid in accordance with the member’s health care benefit plan, including applicable deductibles, co-insurance, calculation of eligible charges and the institution/provider contract with Blue Cross and Blue Shield of Illinois.

Upon request, the physician, facility, health care provider, member or member representative may have access to a copy of the clinical rationale, medical criteria or benefit provision used to make the determination, as well as copies of documents relevant to the appeal.

Actual availability of benefits is subject to member eligibility and other terms, conditions, limitations, provider eligibility and exclusions of the member’s health care benefit plan including but not limited to any pre-existing condition waiting period, if any. For questions regarding health plan benefits available for members, please contact the customer service unit at the telephone number listed on the back of the member’s Blue Cross and Blue Shield I.D. card.

Please be advised that payment of the services of the external independent reviewer will be solely the responsibility of Blue Cross and Blue Shield of Illinois.

Some of the operations of Blue Cross Blue Shield of Illinois are regulated by the Illinois Department of Insurance. If you wish to take up this matter with Illinois Department of Insurance, it maintains a Consumer Division in Chicago at 100 W. Randolph Street, Suite 15-100, Chicago, Illinois 60601-1115 and in Springfield at 320 W. Washington Street, Springfield, Illinois 62767-0001. The Illinois Department of Insurance, Consumer Division, can be contacted by telephone toll free at 1-877-527-9431.

If you have additional questions, please contact me at (insert staff member’s telephone # here).
HMO/PPO/POS MEMBER CLINICAL APPEAL APPROVAL LETTER

Sincerely,

(insert staff name)
(insert staff title)
Appeal Department
Consumer Services Management

Cc: Cathy McClain-Gordon, Senior Director, Consumer Services Management
PPO MEMBER CLINICAL APPEAL DENIAL LETTER

(insert date)

(insert name)
(insert address)
(insert city, state and zip)

Subscriber:
Member:
Group/ID#:

Dear (insert name):

This letter is in response to your request for an appeal of the denial of benefits for (insert appeal request here).

A physician who specializes in (insert specialty type of physician) and who had no involvement in the original denial reviewed your request and the available clinical information. Based on this review, the following determination has been made:

(Insert appeal decision and specific reason for the appeal decision, including the specific benefit provision, guideline, protocol or other criterion on which the decision was based.)

Upon request, the physician, facility, health care provider, member or member representative may have access to a copy of the clinical rationale, medical criteria or benefit provision used to make the determination, as well as copies of documents relevant to the appeal.

Please refer to your member booklet, Health Care Benefit Program description or member’s Certificate to determine if additional levels of appeal are available to you.

Some of the operations of Blue Cross and Blue Shield of Illinois are regulated by the Illinois Department of Insurance. If you wish to take up this matter with Illinois Department of Insurance, it maintains a Consumer Division in Chicago at 100 W. Randolph Street, Suite 15-100, Chicago, Illinois 60601-1115 and in Springfield at 320 W. Washington Street, Springfield, Illinois 62767-0001. The Illinois Department of Insurance, Consumer Division, can be contacted by telephone toll free at 1-877-527-9431.

In addition, you have the right to bring a civil action under section 502(a) of ERISA following an adverse determination of review, provided you are in a group insurance plan that is not a government or church group.

If you have additional questions, please contact me at (insert staff telephone number).

Sincerely,

(insert name)
(insert title)

Appeal Department
Consumer Services Management

Cc: Cathy McClain-Gordon, Senior Director, Consumer Services Management
Policy Name: Member Non-Clinical Appeals  
Policy Number: Utilization Management - 11  
Effective Date: 7/1/03  
Revision Date: 5/10/10  
Review Date: 12/1/09

Policy:
Blue Cross and Blue Shield of Illinois (BCBSIL) will review or facilitate the review for all HMO, BlueChoice, BlueChoice Select and PPO Member Appeals in a thorough, appropriate and timely manner.

Purpose:
• To outline the process for thorough, timely and appropriate handling of member appeals.

Guidelines:
• A member, his/her authorized representative, physician, facility, or other health care provider may request an appeal on behalf of the member.
• If a member selects an authorized representative to act on his/her behalf, written authorization from the member is required at the time of the request.
• All non-clinical appeals will be reviewed by persons not involved in the original decision and not a subordinate of the original decision-maker.
• The member may appeal to the Illinois Department of Insurance at any time.
• The appeal process does not imply that BCBSIL is required to pay for health care services not covered under the Member’s benefit plan document.
• BCBSIL will accept all member appeals regardless of the 180 day submission timeframe required by law for premium groups only. Members must file appeals within the 180 day submission timeframe required by law for self-insured groups.

Definitions:
1. **Non-Clinical Appeal**: An oral or written request that concerns an adverse decision of a previous inquiry or complaint or an action by BCBSIL, its employees, or its subcontractors that has not been resolved to the member’s satisfaction.
   
   **NOTE**: A non-clinical appeal relates to administrative health care services which include but are not limited to membership, access, claim payment, denial of benefits, extension of benefits, out of area benefits and coordination of benefits with another health carrier.

2. **Pre-service Appeal** – a request to change an adverse determination for care or services that must be approved in whole or in part in advance of the member obtaining care or services.
3. **Post-service Appeal** – a request to change an adverse determination for care or services that have already been received by the member.

4. **Health Care Services** - Any service included in the provision of medical care, as outlined in the Member’s benefit plan document, for the purpose of preventing, alleviating, curing or healing human illness or injury.

**Procedure:**

**HMO First Level Appeal**

**Timeframe:** Pre-service must be completed within 15 calendar days of the corporate receipt date. Post-service must be completed within 30 calendar days of the corporate receipt date.

1. Upon receipt of an oral or written appeal, the designated appeal staff will review all information received, document the substance of the appeal and any actions taken.

2. The member may submit any additional comments, documents or other information related to the appeal prior to the first level appeal review.

3. If additional information is needed from the Member, the member is contacted and the additional information is requested within five calendar days of the request.

4. If additional information is needed from a contracted Independent Physician Association (IPA) to evaluate the member’s appeal, the IPA has seven calendar days to respond to the request. If no response is received within seven calendar days, one HMO administered complaint will be assigned. An urgent request for information is forwarded to the IPA Administrator requesting a response within 48 hours.

5. The appeal staff investigates the substance of the appeal and prepares files for the first level appeal review. Brief perspectives are obtained from the member, attached to the case documentation and presented to a designated reviewer.

6. A designated reviewer makes the decision on first level appeal review and forwards the decision back to the Appeal Review Specialist.

7. If the denial is maintained by the designated reviewer, the member is notified of the disposition of the first level appeal review and informed that the case is being referred for the second level appeal review. (See # 9 for required notification elements)

8. Member notification is sent regarding the decision. (See Attachments)

9. The written notification will include:
   - The appeal determination,
   - The principal reason for the determination,
   - A reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based,
   - A statement that the specific benefit provision, guideline, protocol or other similar criterion used in making the determination will be provided upon request,
Member Non-Clinical Appeals

- The titles and qualifications of the individuals participating in the appeal review,
- A statement that copies of all documents relevant to the member’s appeal will be provided upon request.
- A description of further appeal rights, if applicable.

10. The appropriate database and Inquiry Reporting System are updated and the complete file is scanned and stored in the Inquiry Reporting System.

**HMO Second Level Appeal**

1. The BCBSIL Managed Care Appeal Committee meets to review all second level appeal cases.

2. The outcome of the Second Level review by the BCBSIL Managed Care Appeal Committee review is sent to the member in writing within 15 calendar days of the first level decision or 30 calendar days of the initiation of the first level appeal process.

3. Timeframe: Pre-service must be completed within 15 calendar days of the First Level decision. Post-service must be completed within 30 calendar days of the original request.

4. Member notification is sent regarding the decision. (See Attachments)

5. The written notification will include:
   - The appeal determination,
   - The principal reason for the determination,
   - A reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based,
   - A statement that the specific benefit provision, guideline, protocol or other similar criterion used in making the determination will be provided upon request,
   - The titles and qualifications of the individuals participating in the appeal review,
   - A statement that copies of all documents relevant to the member’s appeal will be provided upon request.
   - A description of further appeal rights if applicable.

6. The appropriate database and Inquiry Reporting System are updated and the complete file is scanned and stored in the Inquiry Reporting System.

**PPO / BlueChoice / BlueChoice Select Appeal Process**

Timeframe: Pre-service must be completed within 15 calendar days of the corporate receipt date. Post-service must be completed within 30 calendar days of the corporate receipt date.

1. Upon receipt of an oral or written appeal, the designated appeal staff will review all information received, document the substance of the appeal and any actions taken.
2. The member may submit any additional comments, documents or other information related to the appeal prior to the committee meeting.

3. If additional information is needed from the Member, the member is contacted and the additional information is requested within five calendar days of the request.

4. The appeal staff investigates the substance of the appeal and prepares files for the BCBSIL Appeal Committee. Brief perspectives are obtained from the member, attached to the case documentation and presented to committee members prior to the meeting.

5. The appeal is forwarded the BCBSIL Appeal Committee. The Committee makes a decision and forwards the decision back to the Appeal Review Specialist.

6. Member notification is sent regarding the decision. (See Attachments)

7. The written notification will include:
   
   a. The appeal determination,
   b. The principal reason for the determination,
   c. A reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based,
   d. A statement that the specific benefit provision, guideline, protocol or other similar criterion used in making the determination will be provided upon request,
   e. The titles and qualifications of the individuals participating in the appeal review,
   f. A statement that copies of all documents relevant to the member’s appeal will be provided upon request.
   g. A description of further appeal rights, if applicable.

8. The appropriate database and Inquiry Reporting System are updated and the complete file is scanned and stored in the Inquiry Reporting System.
PPO/BlueChoice/BlueChoice Select
Member Non-Clinical Appeal

1. Phone call, fax or written correspondence initiating the appeal
2. Case prepared and forwarded to BCBSIL Appeal Committee.
3. Case returned to Appeal staff.
4. Appeal Committee reviews and makes a decision.
5. Written notification sent to appropriate parties.
7. End process.

Timeframe: Pre-service must be completed within 15 calendar days. Post-service must be completed within 30 calendar days.

Reviewed 12/1/09
HMO Member Non-Clinical Appeal

Phone call, fax or written correspondence initiating the appeal

Case prepared and forwarded to a designated first level appeal reviewer.

The designated first level appeal reviewer makes a decision.

Denial reversed

Written notification sent to appropriate parties.

Document decision in appropriate databases and Inquiry Reporting System.

End process.

Denial maintained

Written notification sent to appropriate parties.

Document decision in appropriate databases and Inquiry Reporting System.

Appeal is sent to the Level 2 Appeal Committee automatically.

Timeframe: Pre-service must be completed within 15 calendar days. Post-service must be completed within 30 calendar days.

Reviewed 12/1/09
NON-CLINICAL APPEAL HMO MEMBER – Level I Denial Letter

(insert date)

(insert name of facility or physician who initiated the appeal)
(insert address)
(insert city, state and zip)

Subscriber:
Member:
Group/ID#:

Dear (insert name):

Blue Cross and Blue Shield of Illinois has completed the Appeal of your request for benefit coverage for (insert service requested/received).

Your file, including (insert list all documents), was reviewed by the (insert title of Senior Management reviewer).

The denial of your request for coverage has been maintained. The determination was based on (insert specific reason for the appeal decision, including the specific benefit provision, or other criterion on which the decision was based).

Upon request, the physician, facility, health care provider, member or member representative may have access to a copy of the clinical rationale, medical criteria or benefit provision used to make the determination, as well as copies of documents relevant to the appeal.

This case will be forwarded for a second level review by the Managed Care Appeals Committee at their next meeting scheduled for (insert date).

We ask that these procedures be followed:

- If you have additional information for review by the Managed Care Appeals Committee, please send the documentation to:

  (insert staff member name and title)
  Blue Cross and Blue Shield of Illinois
  Consumer Services Management, 24th Floor
  300 East Randolph
  Chicago, Illinois 60601-5099

  Or you may fax the information to (312) 616-1584.

  Each member of the Managed Care Appeals Committee will review the documentation before the meeting in order to be familiar with the case.

Revised 4/1/10
NON-CLINICAL APPEAL HMO MEMBER – Level I Denial Letter

- A letter communicating the decision of the Committee will be mailed within five (5) business days of the meeting.

Some of the operations of Blue Cross and Blue Shield of Illinois (BCBSIL) are regulated by the Illinois Department of Insurance. If you wish to take up this matter with Illinois Department of Insurance, it maintains a Consumer Division in Chicago at 100 W. Randolph Street, Suite 15-100, Chicago, Illinois 60601-1115 and in Springfield at 320 W. Washington Street, Springfield, Illinois 62767-0001. The Illinois Department of Insurance, Consumer Division, can be contacted by telephone toll free at 1-877-527-9431.

In addition, you have the right to bring a civil action under section 502(a) of ERISA following an adverse determination of review, provided you are in a group insurance plan that is not a government or church group.

If you have additional questions, please contact me at (insert staff telephone number).

Sincerely,

(insert name)
Appeal Review Specialist
Appeal Department
Consumer Services Management

Cc:  Cathy McClain-Gordon, Senior Director, Consumer Services Management

Revised 4/1/10
NON-CLINICAL APPEAL DENIAL LETTER HMO MEMBER APPEAL LEVEL II

(insert date)

(insert name)
(insert address)
(insert city, state and zip code)

Subscriber:
Member:
Group/ID#:
Dates or Services Denied:
Case Number:

Dear (insert name),

The Blue Cross and Blue Shield of Illinois Managed Care Appeal Committee has completed their review of the appeal requesting (insert appeal reason).

Your file, including (list all documents), was reviewed by a Committee composed of (insert titles of the Committee members).

The appeal request has been denied. This determination was based on (insert specific reason for the appeal decision, including the specific benefit provision, or other criterion on which the decision was based).

Upon request, the physician, facility, health care provider, member or member representative may have access to a copy of the benefit provision used to make the determination, as well as copies of documents relevant to the appeal.

Some of the operations of Blue Cross and Blue Shield of Illinois (BCBSIL) are regulated by the Illinois Department of Insurance. If you wish to take up this matter with Illinois Department of Insurance, it maintains a Consumer Division in Chicago at 100 W. Randolph Street, Suite 15-100, Chicago, Illinois 60601-1115 and in Springfield at 320 W. Washington Street, Springfield, Illinois 62767-0001. The Illinois Department of Insurance, Consumer Division, can be contacted by telephone toll free at 1-877-527-9431.

Please refer to your member booklet, Health Care Benefit Program description or member’s Certificate to determine if additional levels of appeal are available to you.

In addition, you have the right to bring a civil action under section 502(a) of ERISA following an adverse determination of review, provided you are in a group insurance plan that is not a government or church group.

If you have additional questions, please contact me at (insert staff telephone number).

Revised 12/1/09
NON-CLINICAL APPEAL DENIAL LETTER HMO MEMBER APPEAL LEVEL II

Sincerely,

(insert staff name)
Appeals Review Specialist
Appeal Department
Consumer Services Management

Cc: Cathy McClain-Gordon, Senior Director, Consumer Services Management

Revised 12/1/09
REQUEST FOR EXTRA CONTRACTUAL BENEFITS- Mental Health Level II Denial Letter

(insert date)

(insert name)
(insert address)
(insert city, state and zip code)

Subscriber:
Member:
Group/ID#:
Dates or Services Denied:
Case Number:

Dear (insert name),

The Blue Cross and Blue Shield of Illinois Managed Care Appeals Committee has completed their review of the Appeal in which you requested benefit coverage for extra contractual benefits. The request received was for additional Behavioral Health Benefits such as inpatient and outpatient Mental Health services and inpatient and outpatient Chemical Dependency services.

Your file, including the appeal request and documentation of available benefits was reviewed by a Committee consisting of (insert titles of attending Committee members).

The denial of your request for coverage has been maintained. The Committee’s determination was based on the contractual benefits under the Certificate and not the appropriateness of continued services.

The per-calendar-year benefit maximum for Behavioral Health services is determined by the insured employer group or self pay contract. Based on the terms of the Certificate, the member is not entitled to benefits exceeding the calendar year maximum.

The determination made by Blue Cross and Blue Shield of Illinois in administration of the maximum allowed benefit should not be construed as a denial of treatment. Blue Cross and Blue Shield of Illinois plans does not itself undertake to furnish health care services.

Upon request, the physician, facility, health care provider, member or member representative may have access to a copy of the benefit provision used to make the determination, as well as copies of documents relevant to the appeal.

Some of the operations of Blue Cross and Blue Shield of Illinois are regulated by the Illinois Department of Insurance. If you wish to take this matter up with the Illinois Department of Insurance, it maintains a Consumer Division in Chicago at 100 W. Randolph Street, Suite 15-100, Chicago, Illinois 60601-1115 and in Springfield at 320 W. Washington Street, Springfield, Illinois 62767-0001. The Illinois Department of

Revised 12/1/09
REQUEST FOR EXTRA CONTRACTUAL BENEFITS- Mental Health Level II Denial Letter

Insurance, Consumer Division, can be contacted by telephone toll free at 1-877-527-9431.

In addition, Members may bring a civil action under section 502(a) of ERISA following an adverse determination, provided they are in a group insurance plan that is not a government or church group.

If you have additional questions, please contact me at (insert staff telephone number).

Sincerely,

Insert Name
Appeal Review Specialist
Appeal Department
Consumer Services Management

Cc: Cathy McClain-Gordon, Senior Director, Consumer Services Management

Revised 12/1/09
REQUEST FOR EXTRA CONTRACTUAL BENEFITS- Out Patient Therapy Level II Denial Letter

(insert date)

(insert name)
(insert address)
(insert city, state and zip code)

Subscriber:
Member:
Group/ID#:
Dates or Services Denied:
Case Number:

Dear (insert name),

The Blue Cross and Blue Shield of Illinois Managed Care Appeals Committee has completed their review of the Appeal in which you requested benefit coverage for extra contractual benefits. The request received was for additional outpatient therapy benefits, such as Physical Therapy, Speech Therapy or Occupational Therapy.

Your file, including the appeal request and documentation of available benefits was reviewed by a Committee consisting of (insert titles of attending Committee members).

The denial of your request for coverage has been maintained. The Committee’s determination was based on the contractual benefits under the Certificate and not the appropriateness of continued services.

The per-calendar-year benefit maximum for outpatient therapy services is determined by the insured employer group or self pay contract. Based on the terms of the Certificate, the member is not entitled to benefits exceeding the calendar year maximum.

The determination made by Blue Cross and Blue Shield of Illinois in administration of the maximum allowed benefit should not be construed as a denial of treatment. Blue Cross and Blue Shield of Illinois plans does not itself undertake to furnish health care services.

Upon request, the physician, facility, health care provider, member or member representative may have access to a copy of the benefit provision used to make the determination, as well as copies of documents relevant to the appeal.

Some of the operations of Blue Cross and Blue Shield of Illinois are regulated by the Illinois Department of Insurance. If you wish to take this matter up with the Illinois Department of Insurance, it maintains a Consumer Division in Chicago at 100 W. Randolph Street, Suite 15-100, Chicago, Illinois 60601-1115 and in Springfield at 320 W. Washington Street, Springfield, Illinois 62767-0001. The Illinois Department of Insurance, Consumer Division, can be contacted by telephone toll free at 1-877-527-9431.

Revised 12/1/09
REQUEST FOR EXTRA CONTRACTUAL BENEFITS- Out Patient Therapy Level II Denial Letter

In addition, Members may bring a civil action under section 502(a) of ERISA following an adverse determination, provided they are in a group insurance plan that is not a government or church group.

If you have additional questions, please contact me at (insert staff telephone number).

Sincerely,

Insert Name
Appeal Review Specialist
Appeal Department
Consumer Services Management

Cc:   Cathy McClain-Gordon, Senior Director, Consumer Services Management

Revised 12/1/09
NON-CLINICAL APPEAL APPROVAL LETTER HMO MEMBER

(Date)

(Name of facility or physician who initiated the appeal)

(Address)

(City, state and zip)

Subscriber:
Member:
Group/ID#:

Dear (Name):

Blue Cross and Blue Shield of Illinois Managed Care Appeal Committee has completed the Appeal of your request for benefit coverage for (Service requested/received).

Your file, including (List all documents), was reviewed by a Committee consisting of (Attend Committee member titles).

OR if Level I Determination

Your file, including (List all documents), was reviewed by a (Senior Management staff member title).

Based on this review the original denial was reversed. This determination was based on (Determination rationale and any applicable benefit provision or coverage criteria).

(if outstanding claims are present leave this paragraph in, if not omit) Our office has requested that claim(s) for the above referenced date(s) of service be processed and paid in accordance with the member’s benefit plan, including applicable deductibles, co-insurance, calculation of eligible charges and the institution/provider contract with Blue Cross and Blue Shield of Illinois.

Upon request, the physician, facility, health care provider, member or member representative may have access to a copy benefit provision used to make the determination, as well as copies of documents relevant to the appeal.

Actual availability of benefits is subject to member eligibility and other terms, conditions, limitations and exclusions of the member’s health care benefit plan including but not limited to any pre-existing condition waiting period, if any. For questions regarding health plan benefits available for members, please contact the Customer Service Unit at the telephone number listed on the back of the member’s Blue Cross and Blue Shield I.D. card.

Revised 12/1/09
NON-CLINICAL APPEAL APPROVAL LETTER HMO MEMBER

Some of the operations of Blue Cross Blue Shield of Illinois are regulated by the Illinois Department of Insurance. If you wish to take up this matter with Illinois Department of Insurance, it maintains a Consumer Division in Chicago at 100 W. Randolph Street, Suite 15-100, Chicago, Illinois 60601-1115 and in Springfield at 320 W. Washington Street, Springfield, Illinois 62767-0001. The Illinois Department of Insurance, Consumer Division, can be contacted by telephone toll free at 1-877-527-9431.

If you have additional questions, please contact me at (insert staff telephone number).

Sincerely,

(insert staff name)
Appeal Review Specialist
Appeal Department
Consumer Services Management

Cc: Cathy McClain-Gordon, Senior Director, Consumer Services Management

Revised 12/1/09
PPO / POS NON-CLINICAL APPEAL APPROVAL LETTER

(insert date)

(insert name)
(insert address)
(insert city, state and zip)

Subscriber:  
Member:  
Group/ID#:  

Dear (insert name):

The Blue Cross and Blue Shield of Illinois Appeal Committee has completed the Appeal of your request for benefit coverage for (insert service requested/received).

Your file including (insert list all documents) was reviewed by a Committee consisting of (insert titles of attending Committee members).

Based on this review, the original denial was reversed. This determination was based on (insert determination rationale and any applicable benefit provision or coverage criteria).

If outstanding claims are present leave this paragraph in, if not omit) Our office has requested that claim(s) for the above referenced date(s) of service be processed and paid in accordance with the Member’s benefit plan document including applicable deductibles, co-insurance, calculation of eligible charges and the institution/provider contract with Blue Cross and Blue Shield of Illinois.

Upon request, the physician, facility, health care provider, member or member representative may have access to a copy of the benefit provision used to make the determination, as well as copies of documents relevant to the appeal.

Actual availability of benefits is subject to member eligibility and other terms, conditions, limitations and exclusions of the member’s health care benefit plan including but not limited to any pre-existing condition waiting period, if any. For questions regarding health plan benefits available for members, please contact the Customer Service Unit at the telephone number listed on the back of the member’s Blue Cross and Blue Shield I.D. card.

Some of the operations of Blue Cross and Blue Shield of Illinois (BCBSIL) are regulated by the Illinois Department of Insurance. If you wish to take up this matter with Illinois Department of Insurance, it maintains a Consumer Division in Chicago at 100 W. Randolph Street, Suite 15-100, Chicago, Illinois 60601-1115 and in Springfield at 320 W. Washington Street, Springfield, Illinois 62767-0001. The Illinois Department of Insurance, Consumer Division, can be contacted by telephone toll free at 1-877-527-9431.

If you have additional questions, please contact our office at (insert staff telephone #).

Sincerely,

(insert staff name)
Appeal Review Specialist
Appeal Department
Consumer Services Management

Cc:  Cathy McClain-Gordon, Senior Director, Consumer Services Management

Revised 12/1/09
DATE

(insert name)
(insert address)
(insert city, state and zip code)

Subscriber:
Member:
Group/ID#:
Dates or Services Denied:
Case Number:

Dear (insert name):

The Blue Cross and Blue Shield of Illinois Appeal Committee has completed their review of the appeal requesting (insert appeal reason).

Your file, including (list all documents), was reviewed by a Committee composed of (insert titles of the attending Committee members).

The appeal request has been denied. This determination was based on (insert specific reason for the appeal decision, including the specific benefit provision, or other criterion on which the decision was based).

Upon request, the physician, facility, health care provider, member or member representative may have access to a copy of the benefit provision used to make the determination, as well as copies of documents relevant to the appeal.

Some of the operations of Blue Cross and Blue Shield of Illinois (BCBSIL) are regulated by the Illinois Department of Insurance. If you wish to take up this matter with Illinois Department of Insurance, it maintains a Consumer Division in Chicago at 100 W. Randolph Street, Suite 15-100, Chicago, Illinois 60601-1115 and in Springfield at 320 W. Washington Street, Springfield, Illinois 62767-0001. The Illinois Department of Insurance, Consumer Division, can be contacted by telephone toll free at 1-877-527-9431.

Please refer to your member booklet, Health Care Benefit Program description or member’s Certificate to determine if additional levels of appeal are available to you.

In addition, you have the right to bring a civil action under section 502(a) of ERISA following an adverse determination of review, provided you are in a group insurance plan that is not a government or church group.

If you have additional questions, please contact me at (312) 653 – (insert staff telephone #).

Sincerely,

(insert staff name)
Appeal Review Specialist
Appeals Department
Consumer Management Services

Cc: Cathy McClain-Gordon, Senior Director, Consumer Services Management

Revised 12/1/09
PPO / POS NON-CLINICAL APPEAL OVER ALLOWED AMOUNT LETTER

DATE

(insert name)
(insert address)
(insert city, state and zip code)

Subscriber:
Member:
Group/ID#:
Dates or Services Denied:
Case Number:

Dear (insert name):

The Blue Cross and Blue Shield of Illinois Appeal Committee has completed their review of the appeal requesting (insert appeal reason).

Your file, including (list all documents), was reviewed by a Committee composed of (insert titles of the attending Committee members).

The appeal request has been denied. This determination was based on allowed benefits under your health plan which states out of network services are covered at ***** after the deductible. The member may be billed for the amount over the allowance for services provided by an out of network provider. The Committee determined the charges processed correctly.

Upon request, the physician, facility, health care provider, member or member representative may have access to a copy of the rationale, medical criteria or benefit provision used to make the determination, as well as copies of documents relevant to the appeal.

Some of the operations of Blue Cross and Blue Shield of Illinois (BCBSIL) are regulated by the Illinois Department of Insurance. If you wish to take up this matter with Illinois Department of Insurance, it maintains a Consumer Division in Chicago at 100 W. Randolph Street, Suite 15-100, Chicago, Illinois  60601-1115 and in Springfield at 320 W. Washington Street, Springfield, Illinois 62767-0001. The Illinois Department of Insurance, Consumer Division, can be contacted by telephone toll free at 1-877-527-9431.

Please refer to your member booklet, Health Care Benefit Program description or member’s Certificate to determine if additional levels of appeal are available to you.

In addition, you have the right to bring a civil action under section 502(a) of ERISA following an adverse determination of review, provided you are in a group insurance plan that is not a government or church group.

If you have additional questions, please contact me at (312) 653 – (insert staff telephone #).

Sincerely,

(insert staff name)
Appeal Review Specialist
Appeals Department
Consumer Services Management

Cc:  Cathy McClain-Gordon, Senior Director, Consumer Services Management

Revised 12/1/09
Policy:

Blue Cross and Blue Shield of Illinois complies with state legislative requirements that emergency room services are covered in accordance with prudent layperson standards. HMO and BlueChoice members are financially responsible for emergency room co-payments when not admitted to the hospital as a result of the emergency room visit.

Purpose:

- To outline financial responsibility for emergency claims
- To detail how members can access emergency services

Definitions:

- **Prudent layperson** - a person who has an average knowledge of health and medicine.

- **Emergency Medical Condition** - a medical condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to, severe pain) such that a prudent layperson could reasonably expect the absence of immediate medical attention to result in:
  a. placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
  b. serious impairment to bodily functions; or
  c. serious dysfunction of any bodily organ or part.

Procedure:

A. **HMO and BlueChoice**:

1. A member experiencing an emergency medical condition:
   - may or may not contact his Primary Care Physician (PCP) for guidance. Note: If contacted, the **Blue Choice** PCP is obliged to provide, arrange for, or otherwise facilitate all needed emergency services. **For HMO Independent Physician Associations (IPAs), the HMO PCP is responsible for coordinating and/or authorizing “in area” emergency services which is defined as those medical services and supplies provided within a 30-mile radius of the IPA or IPA affiliated hospital site in which the member is enrolled.**
   - has the option to go to an emergency room without prior guidance from or authorization by the PCP if he is experiencing an emergency as defined using the prudent layperson definition.
2. Prior authorization or approval by the contracting Independent Practice Association (IPA) or PCP is not required for a member’s emergency services.
B. **HMO:**

1. The contracting IPA will pay for all physicians and other professional charges for emergency services provided to a member *within a 30-mile radius of the IPA or IPA affiliated hospital site in which the member is enrolled.*

2. *Unless authorized by the IPA PCP,* the contracting IPA is not responsible for physician and other professional charges for emergency services provided to a member *outside of the 30-mile radius of the IPA or IPA affiliated hospital site in which the member is enrolled.*

3. The HMO is always responsible for facility charges related to emergency room services.

4. *Unless authorized by the IPA PCP,* the HMO is responsible for all professional fees related to an emergency visit outside *of the 30 mile radius of the IPA or IPA affiliated hospital site in which the member is enrolled.*

5. If the member is hospitalized as a result of an emergency medical condition within *a 30-mile radius of the IPA or IPA affiliated hospital in which the member is enrolled:*
   - All inpatient days will be charged to the contracting IPA.
   - *The HMO is responsible for all professional fees prior to the IPA’s point of notification and the* contracting IPA is responsible for all “in-area” inpatient physician and professional fees from the point of notification.

6. If the member is hospitalized outside *of the 30-mile radius of the IPA or IPA affiliated hospital site in which the member is enrolled* as a result of an emergency medical condition:
   - The HMO is responsible for all physician and other professional charges.
   - Inpatient days will not be charged to the contracting IPA.

C. **BlueChoice:**

1. BlueChoice is responsible for facility and professional charges related to emergency room services.