BlueCross BlueShield of Florida
An Independent Licensee of the Blue Cross and Blue Shield Association

PROVIDER INTERNAL POST-SERVICE CLAIM APPEAL PROCESS Q&A*

What is an appeal? *An appeal is when a provider formally requests (via appeal form or letter) a reconsideration of a previously adjudicated claim from the contracting Blue Plan, 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 Provider Agreement for dispute resolution options.

How do I request an appeal?

Providers should submit a formal request via the appropriate form developed for provider usage. A letter, on letterhead, may accompany the form and contain:

- 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

Please be sure to include any supporting information or explanation, including any relevant procedural notes, chart notes and/or medical records appropriate to the review. Forms must be properly completed or letters must contain all relevant information to be processed as an appeal. Incomplete forms and letters will not be processed.

Where do I send my appeal request?

All appeal correspondence should be submitted to the following:

Blue Cross and Blue Shield of Florida Appeals
Birmingham Service Center
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 his or her Participating or Preferred Provider Agreement or legal settlement in effect.

**Not applicable to predeterminations, provider audits or appeals regarding termination from network.*

Appeal to Independent Review Organization

Provider External Review Process
(if applicable under the terms of your agreement)

Independent Medical Expert Consulting Services, Inc. (IMEDECS) has been selected as the Independent Review Organization for medical necessity and billing disputes.

Provider 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 Current Procedural Terminology (CPT®) modifier, and/or other reassignment of a code. **An individual provider must exhaust the initial internal appeal process described above.**

Provider Medical Necessity Disputes

This review process seeks to resolve disputes concerning services that are determined to be noncovered due to not being medically necessary or are experimental or investigational in nature. **The provider must exhaust the post-service internal appeal process to qualify for the external review process.** The provider may submit a written request to IMEDECS within 60 days from the date of the internal post-service appeal non-coverage decision. Providers seeking external review shall submit **all** supporting documentation and pay a filing fee of $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
Attention: Administrative Assistant
6802 Paragon Place, Suite 440
Richmond, VA 23230
Main: 215-855-4633, ext. 332
Fax: 215-855-5318

Refer to Provider Billing and Medical Necessity Disputes for information regarding the external review process and applicable filing fees.