BCBSNC Revamps and Clarifies Provider Appeal Process

BCBSNC has agreed to delay implementation of a 90-day timeframe limitation on Level I Provider Appeals to allow additional time to clarify the new process for the provider community. Specifically, any provider (professional and institutional) with a claim that was adjudicated and denied prior to August 21, 2008 and related to Post-Service Physician Billing/Coding Disputes will have 180 calendar days from the claim adjudication date to submit the Level I Provider Appeal. If the claim adjudication date is August 21, 2008 or after, the provider will have 90 calendar days to submit the Level I Provider Appeal.

The provider will have 180 calendar days from the claim adjudication date to submit a Level I Provider Appeal for any claim related to Post-Service Medical Necessity Review that was adjudicated prior to September 15, 2008. If the claim adjudication date is September 15, 2008 or after, the provider will have 90 calendar days to submit the appeal from the adjudication date.

Level I Provider Appeals can be submitted without obtaining written consent from the patient. The Level I Provider Appeal process does not apply to government programs such as the Federal Employees Health Program, NC Smart Choice, and NCCHIPS.

BCBSNC decided to reduce the number of days from 180 days to 90 days for administrative efficiency and because they had seen few appeals exceeding 90 days. As a result of the medical society lawsuit settlement agreement (Thomas/Love) BCBSNC will be adding a new level of medical necessity and billing appeal for physicians and physician groups that will be performed by an Independent Review Organization after the internal Level I Provider Appeal process has been exhausted. As outlined in the Settlement, there is a fee associated with the Level II Provider Appeal process. The fee will be refunded in the event the physician or physician group prevails in the appeal. Physician and Physician Groups must file their Level II written request for appeal of a billing dispute within 90 days of the date of the letter denying the Level I Appeals. For Level II Medical Necessity appeals, physicians and physician groups must file their written request for appeal within 60 days of the date of the letter denying their Level I appeal. BCBSNC will provide physicians notification and instruction for submission of a Level II Billing Dispute once the process has been implemented.

More information about the Level I and Level II Provider Appeal process and the new Provider Appeal form can be found on the BCBSNC provider Web site at http://www.bcbsnc.com/providers/appeals. Below is a chart showing the appeal process before and after the changes are made.

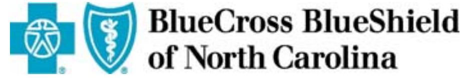
BCBSNC Appeal Process Quick Reference Guide

Process	***Old** Post-Service Provider Courtesy Review (PCR) Process*	***New Post-Service Provider** Appeal Process*	***Member** Appeal Process (pre-service or post-service)*
Medical Necessity Review Appeals (Post Service): Applies to medical necessity determinations, cosmetic services, investigational/experimental services, and no authorization for inpatient stay. *Provider Courtesy Reviews continue to exist for State PPO Prior Auth and Quantity Limit requests for Pharmacy only	PCR: BCBSNC Review (180 day Filing Deadline) Level II: No Appeal Process	***LEVEL I IMPLEMENTED 9/15/2008*** Level I*: BCBSNC Review (90-Day Filing Deadline: 180-Day Deadline for claims adjudicated and denied before 9/15/08) ***LEVEL II IMPLEMENTION DATE TBD*** Level II*: Independent Review Organization/Fee Applies (60-Day Filing Deadline) **No Patient Written Consent Required*	Level I: BCBSNC Review (180 day Filing Deadline) Level II: BCBSNC and external review panel (180 days from the Level I denial) Level III NCDOI External Review Program (60-Day Filing Deadline) ** Patient Written Consent Required*
Physician Billing Disputes (Post Service): Applies to integral part of primary service, mutually exclusive services, services not eligible for separate reimbursement, incidental denials, surgical global denials	BCBSNC Courtesy Review	***LEVEL I IMPLEMENTED 8/21/2008*** Level I: BCBSNC Review* (90-Day Filing Deadline) 180 days for claims that adjudicated before 08/21/08 ***LEVEL II IMPLEMENTATION DATE TBD*** ***Level II: Independent Review Organization/Fee Applies*** (90-Day Filing Deadline) **Includes UCR Appeals for Non-Participating Providers*	Level I*: BCBSNC Review (180 day Filing Deadline) Level II: BCBSNC and external review panel (180 days from Level I denial) Level III: NCDOI External Review Program (60-Day Filing Deadline) ** Patient Written Consent Required*

Pre-Service Requests: AIM (High-Tech Diagnostic Imaging), Magellan (MHSA), Value Options (MHSA for State PPO)	Provider Courtesy Review: Submit a courtesy review request to AIM, Magellan, or Value Options	Provider Courtesy Review: Submit a courtesy review request to AIM, Magellan, or Value Options	AIM, Value Options: Level I and Level II with BCBSNC Magellan : Level I to Magellan, Level II to BCBSNC Level III: NCDOI External Review Program (60-day Filing Deadline) *Patient written consent required.
All other Pre-Service Requests (Predetermination of Services not on the Prior Plan Approval list)	Not available	Not available	Level I*: BCBSNC Review (180 day from denial notice) Level II: BCBSNC and external review panel (180 days from level I denial) Level III: NCDOI External Review Program (60-Day Filing Deadline) ** Patient Written Consent Required*
Pre-Service reviews for MHPO (Utilization Management) for inpatient authorization, Prior Plan Approval, Prior Auth and Quantity Limit pharmacy requests performed by Member Health Partnerships (MHPO) department.	Pre service through MHPO department at BCBSNC	Pre service through MHPO department at BCBSNC	Not applicable

*** Member appeal column is subject to the laws surrounding the Member Appeal Process and is not indicative of all member appeal rights. ***

LEVEL ONE PROVIDER APPEAL FORM



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Section I: Patient Information

Alpha Prefix (Copy from the member's BCBSNC identification card) **Patient Date of Birth**

Subscriber Number **(Copy from the member's BCBSNC identification card)**

Patient Name (First, middle initial, last)

Section II: Physician Information

Requesting Physician (Print first, last name) **Requesting Physicians Signature** (Signature & date)

Fax - - **Phone** - -

BCBSNC Physician Number **Physician NPI Number**

Physician Mailing Address (Street or P.O. Box, City, State & Zip Code)

Section III: Appeal Information

Date of Service - - **Date of Notification of Payment** - -

CPT Codes - **Diagnosis Codes** .

\- .

Claim Identification Number

DENIAL REASON: Must be Post-Service.
For Inter-Plan Programs Use Only: This form should be used for coding, bundling, or fee denials regarding non-NC members only. All other requests for Appeal review should be submitted using the Provider/Doctor Claim Inquiry Form in the Blue Book Provider Manual.

CODING, BUNDLING, or FEE DENIALS
Fax# 919-287-8708
- ☐ **Integral Part of Primary Service**
- ☐ **Mutually Exclusive**
- ☐ **Services Not Eligible for Separate Reimbursement**
- ☐ **Incidental Denial**
- ☐ **Surgical Global Period Denial**
- ☐ **Re-bundling**

MEDICAL NECESSITY DENIALS
Fax # 919-287-8709
- ☐ **Inpatient vs. Observation**
- ☐ **Not Medically Necessary**
- ☐ **Investigational**
- ☐ **Cosmetic**
- ☐ **Experimental**

ADMINISTRATIVE DENIALS
Fax# 919-287-8709
- ☐ **No Authorization for Inpatient Hospital Admission**

---State PPO Authorization Only---
Fax# 919-765-2322
- ☐ **Pharmacy – May Be Pre-Service**

Comments (If additional space is needed, please use the back of this form)

☐ **Records Attached**

This form is intended for use only when requesting a review for post service coding denials, services not considered medically necessary or administrative denials. Completed forms accompanied by any supporting documentation should be sent to**: Provider Appeal Department,** ***Blue Cross and Blue Shield of North Carolina, P.O. Box 2291, Durham, NC 27702-2291 or Fax: Billing/Coding (919) 287-8708 or Medical Necessity/Administrative Denials Fax: (919) 287-8709.***

Inquiry requests for Federal Employees Program (FEP), State Comprehensive Major Medical (CMM) or for reasons other than review of a claim denial not specific to post service denials should not be requested by use of this form. Please refer to the Blue Book provider manual located on the BCBSNC Web site for providers at ***bcbsnc.com/providers/blue-book*** or contact your local Network Management field office for assistance with the claims inquiry process.

Inclusive Health: North Carolina's High Risk Pool Begins Coverage January 1, 2009

On October 20th, North Carolina will become the 35th state to offer a high risk health insurance pool. This represents a major development in the health insurance landscape of North Carolina as thousands of North Carolinians with medical conditions will now have access to more affordable coverage. The North Carolina Health Insurance Risk Pool, Inc. will offer three plans under the brand name of Inclusive Health, with coverage effective on January 1, 2009.

The Pool was established by the 2007 North Carolina General Assembly with the support of the North Carolina Medical Society. It is designed primarily for individuals with medical conditions that cause them to face higher health insurance premiums in the individual market. Eligible individuals will pay premiums at 175% of the standard rate, a considerable reduction from the much higher rate they would face from commercial plans. Because individuals will pay far less than their expected medical costs, Inclusive Health, as with all high risk pools, is designed to operate at a loss, with the state subsidizing the difference.

There are multiple ways individuals can qualify, but most people will be eligible due to a medical condition. For example, those paying premiums higher than the rate offered under Inclusive Health, those denied coverage, or those with certain conditions (such as cancer, multiple sclerosis, or COPD) qualify.[1] Inclusive Health will also be an option for federally-qualified HIPAA-eligibles who have maintained continuous coverage. The third group of potential eligibles are individuals who qualify due to the effects of international trade on their employment under the Trade Adjustment Assistance Act.

Inclusive Health is not for people who are eligible for or enrolled in group coverage. The Risk Pool enabling legislation makes it an unfair trade practice to arrange for an individual employee to apply for the Pool for the purpose of separating them from their group coverage. Medicare and Medicaid eligibles are also ineligible for the Pool.

Under the terms of the Risk Pool enabling legislation, provider reimbursement is defined as follows:

"**§ 58-50-190. Risk Pool rates and policy forms.**

(d) Provider reimbursement rates under Pool coverage shall be limited to the rates allowed for providers under the Medicare Program for those services covered by Medicare. The Board shall establish reimbursement rates for services for which Medicare has not established an allowed rate. Providers rendering medical care to an insured shall accept payment of the amount established under this subsection, including any applicable deductible, coinsurance, or co-payment amounts, as payment in full for services rendered."

Inclusive Health is working with MedCost to recontract with its statewide physician network to accept Inclusive Health patients. MedCost mailed an amendment out in August for review and signature by its physicians and hospitals. Your participation for your patients who may be covered by Inclusive Health will mean a significant out-of-pocket savings to them in deductible and coinsurance amounts as they attempt to manage their many health care costs. Inclusive Health is regulated as an insurance company by the Department of Insurance and subject to the prompt pay law.

As North Carolina physicians, you can help ensure that as many folks as possible receive coverage from this plan in two ways. First, if you know of someone who may be eligible, refer them to the Inclusive Health website at http://www.inclusivehealth.org or have them call the call center at (866-665-2117). Inclusive Health is interested in addressing local MGMA and Medical Society meetings to present the program and answer questions. Please call (919)783-5766 to arrange a presentation and question and answer session.

We need your help in getting the word out as soon as possible to people you know who may qualify. Inclusive Health will normally have a pre-existing condition waiting period of twelve months. However, individuals who enroll during the first six months of the plan from January thru June 2009 will have only a six month waiting period. After that the waiting period will revert to twelve months.

We look forward to working with you to make Inclusive Health a success for the many people you encounter who may need it.

	Plan A - PPO	Plan B – PPO	Plan C - HDHP
Annual Deductible	$1,000	$2,500	$5,000
Coinsurance	80% in-network 50% out-of-network	80% in-network 50% out-of-network	100% in-network 100% out-of-network
Annual Out-of-Pocket Maximum	$2,000 in-network $4,000 out-of-network	$4,000 in-network $5,000 out-of-network	$5,000 in-network $5,000 out-of-network
Lifetime Maximum	$1,000,000	$1,000,000	$1,000,000
Physician Office Visits	$20 copay for PCP $40 copay for specialist Not subject to coinsurance or deductible	$20 copay for PCP $40 copay for specialist Not subject to coinsurance or deductible	Subject to deductible and coinsurance
Other Physician Services	Subject to coinsurance and deductible	Subject to coinsurance and deductible	Subject to coinsurance and deductible