City of Corpus Christi

ADMINISTRATIVE PROCEDURE

NO. HR 43.0

SUBJECT: MEDICAL CLAIM APPEALS PROCESS

EFFECTIVE DATE: 06/12/19

APPROVED: _____ **DATE:** 6/12/19

Steven Viera, Director of Human Resources

I. PURPOSE

This procedure describes how members may file an appeal for a medical claim if the Claim Administrator denies all or part of your claim. If the claim is denied in whole or in part, the Claim Administrator will send you a written notice describing the reasons for the determination with reference to the Health Benefit Plan provisions and, upon request ,will provide all Claim Administrator internal rules, guidelines, or protocols relied on in arriving at the determination.

II. SCOPE

This procedure applies to all members who are insured on the City's medical plan. Notwithstanding anything in this procedure to the contrary, the terms of the applicable benefit plan document shall control.

III. PROCEDURE

The member should follow the Claim Filing and Appeals Procedures located in the Summary Plan Description (SPD). The SPD can be downloaded from benefitscc.org, but the relevant pages also follow this procedure as Appendix A. An appeal form Appendix B follows Appendix A.

There are two levels of appeals available to members, explained in detail in Appendix A. The first level Internal Appeal is filed with Blue Cross and Blue Shield of Texas. If the Internal Appeal determination denies the claim in whole or in part, a second level External Appeal can be filed with an Independent Review Organization (IRO). There are specific appeals timing and documentation requirements that are governed by Federal regulations which are also outlined in Appendix A. Additionally, the initial Internal written appeal determination letter will explain the steps needed to escalate the appeal to the External level.

If the IRO's External Appeal decision continues to deny or partially deny your claim, you may raise a final review request to the City of Corpus Christi. The City of Corpus Christi review committee will not review or overturn medical decisions made by the IRO; the committee's review will be limited to reviewing the appeal for compliance with our plan documents. Within 30 days following your receipt of the final external review decision, complete the request for review form attached as Appendix C and

submit all relevant documentation including the determination letters received in response to both the Internal and External IRO appeal along with an explanation of the issue to:

City of Corpus Christi
Human Resources – Health Benefits Manager
1201 Leopard St.
Corpus Christ, TX 78401

The Health Benefits Manager or designee will review your submission and request any missing documentation from you and may request additional information from the Claims Administrator. A Claims Review Committee composed of the Director of Human Resources, the Assistant Director of Human Resources, and the Health Benefits Manager or designees will review your appeal and issue a written determination within 60 days.

IV. QUESTIONS REGARDING THIS PROCEDURE

Questions regarding this Procedure shall be directed to the Director of Human Resources, or designee, who may be contacted at 361-826-3315.

If a Claim Is Denied or Not Paid in Full

On occasion, the Claim Administrator may deny all or part of your claim. There are a number of reasons why this may happen. We suggest that you first read the *Explanation of Benefits* summary prepared by the Claim Administrator; then review this Benefit Booklet to see whether you understand the reason for the determination. If you have additional information that you believe could change the decision, send it to the Claim Administrator and request a review of the decision as described in **Claim Appeal Procedures** below.

If the claim is denied in whole or in part, you will receive a written notice from the Claim Administrator with the following information, if applicable:

- The reasons for determination;
- A reference to the Health Benefit Plan provisions on which the determination is based, or the contractual, administrative or protocol for the determination;
- A description of additional information which may be necessary to perfect the claim and an explanation of why such material is necessary;
- Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;
- In certain situations, a statement in non-English language(s) that written notice of claim denials and certain other benefit information may be available (upon request) in such non-English language(s);
- In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by the Claim Administrator;
- The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
- Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge upon request;
- An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's medical circumstances, if the denial was based on medical necessity, experimental treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request;
- In the case of a denial of an Urgent Care Clinical Claim, a description of the expedited review procedure applicable to such claims. An Urgent Care Clinical Claim decision may be provided orally, so long as a written notice is furnished to the claimant within three days of oral notification;
- Contact information for applicable office of health insurance consumer assistance or ombudsman.

Timing of Required Notices and Extensions

Separate schedules apply to the timing of required notices and extensions, depending on the type of Claim. There are three types of Claims as defined below.

1. **Urgent Care Clinical Claim** is any Pre-Service Claim that requires Preauthorization, as described in this Benefit Booklet, for benefits for medical care or Treatment with respect to which the application of regular time periods for making health Claim decisions could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or Treatment.
2. **Pre-Service Claim** is any non-urgent request for benefits or a determination with respect to which the terms of the benefit plan condition receipt of the benefit on approval of the benefit in advance of obtaining medical care.
3. **Post-Service Claim** is notification in a form acceptable to the Claim Administrator that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service

rendered or furnished, the date of service, the diagnosis, the Claim charge, and any other information which the Claim Administrator may request in connection with services rendered to you.

Urgent Care Clinical Claims*

Type of Notice or Extension	Timing
If your Claim is incomplete, the Claim Administrator must notify you within:	**24 hours**
If you are notified that your Claim is incomplete, you must then provide completed Claim information to the Claim Administrator within:	**48 hours after receiving notice**
The Claim Administrator must notify you of the Claim determination (whether adverse or not):	
if the initial Claim is complete as soon as possible (taking into account medical exigencies), but no later than:	**72 hours**
after receiving the completed Claim (if the initial Claim is incomplete), within:	**48 hours**

* You do not need to submit Urgent Care Clinical Claims in writing. You should call the Claim Administrator at the toll-free number listed on the back of your Identification Card as soon as possible to submit an Urgent Care Clinical Claim.

Pre-Service Claims

Type of Notice or Extension	Timing
If your Claim is filed improperly, the Claim Administrator must notify you within:	**5 days**
If your Claim is incomplete, the Claim Administrator must notify you within:	**15 days**
If you are notified that your Claim is incomplete, you must then provide completed Claim information to the Claim Administrator within:	**45 days after receiving notice**
The Claim Administrator must notify you of any adverse Claim determination:	
if the initial Claim is complete, within:	**15 days***
if the initial Claim is incomplete, within:	**30 days****
If you require post-stabilization care after an Emergency within:	**the time appropriate to the circumstance not to exceed one hour after the time of request**

* This period may be extended one time by the Claim Administrator for up to 15 days, provided that the Claim Administrator both (1) determines that such an extension is necessary due to matters beyond the control of the Plan and (2) notifies you, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Claim Administrator expects to render a decision.

** If additional information is necessary to decide the claim, the time period for making the decision is suspended from the day you are notified to the earlier of: (1) the date on which your response is received by the Claim Administrator; or (2) the date established by the Claim Administrator for the furnishing of the requested information (at least 45 days). The number of days shown above includes a 15-day extension.

Post-Service Claims

Type of Notice or Extension	Timing
If your Claim is incomplete, the Claim Administrator must notify you within:	**30 days**
If you are notified that your Claim is incomplete, you must then provide completed Claim information to the Claim Administrator within:	**45 days after receiving notice**
The Claim Administrator must notify you of the Claim determination (whether adverse or not):	
if the initial Claim is complete, within:	**30 days***
if the initial Claim is incomplete, within:	**45 days****

* This period may be extended one time by the Claim Administrator for up to 15 days, provided that the Claim Administrator both (1) determines that such an extension is necessary due to matters beyond the control of the Plan and (2) notifies you in writing, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Claim Administrator expects to render a decision.

** If additional information is necessary to decide the claim, the time period for making the decision is suspended from the day you are,notified to the earlier of: (1) the date on which your response is received by the Claim Administrator; or (2) the date established by the Claim Administrator for the furnishing of the requested information (at least 45 days). The number of days shown above includes a 15-day extension.

Concurrent Care

For benefit determinations relating to care that is being received at the same time as the determination, such notice will be provided no later than 24 hours after receipt of your Claim for benefits.

Claim Appeal Procedures

Claim Appeal Procedures - Definitions

An "**Adverse Benefit Determination**" means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide in response to a claim, Pre-Service Claim or Urgent Care Clinical Claims, or make payment for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. If an ongoing course of treatment had been approved by the Claim Administrator or your Employer and the Claim Administrator or your Employer reduces or terminates such treatment (other than by amendment or termination of the Employer's benefit plan) before the end of the approved treatment period, that is also an Adverse Benefit Determination. A Rescission of coverage is also an Adverse Benefit Determination.

A "**Final Internal Adverse Benefit Determination**" means an Adverse Benefit Determination that has been upheld by the Claim Administrator or your Employer at the completion of the Claim Administrator's or Employer's internal review/appeal process.

Expedited Clinical Appeals

If your situation meets the definition of an expedited clinical appeal, you may be entitled to an appeal on an expedited basis. An **expedited clinical appeal** is an appeal of a clinically urgent nature related to health care services, including but not limited to, procedures or treatments ordered by a health care provider, as well as continued hospitalization. Before authorization of benefits for an ongoing course of treatment/continued hospitalization is terminated or reduced, the Claim Administrator will provide you with notice at least 24 hours before the previous benefits authorization ends and an opportunity to appeal. For the ongoing course of treatment, coverage will continue during the appeal process.

Upon receipt of an expedited pre-service or concurrent clinical appeal, the Claim Administrator will notify the party filing the appeal, as soon as possible, but no more than 24 hours after submission of the appeal, of all the information needed to review the appeal. Additional information must be submitted within 24 hours of request. The Claim

Administrator shall render a determination on the appeal within 24 hours after it receives the requested information, but no later than 72 hours after the appeal has been received by the Claim Administrator.

How to Appeal an Adverse Benefit Determinations

You have the right to seek and obtain a full and fair internal review of any determination of a claim, any determination of a request for Preauthorization, or any other determination made by the Claim Administrator in accordance with the benefits and procedures detailed in your Health Benefit Plan.

An appeal of an Adverse Benefit Determination may be filed by you or a person authorized to act on your behalf. In Urgent Care Clinical Claim situations, a health care provider may appeal on your behalf. With the exception of Urgent Care Clinical Claim situations, your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative. To obtain an Authorized Representative Form, you or your representative may call the Claim Administrator at the number on the back of your ID card.

If you believe the Claim Administrator incorrectly denied all or part of your benefits, you may have your claim reviewed. The Claim Administrator will review its decision in accordance with the following procedure:

- Within 180 days after you receive notice of a denial or partial denial, you may call or write to the Claim Administrator's Administrative Office. The Claim Administrator will need to know the reasons why you do not agree with the denial or partial denial. Send your request to:

  Claim Review Section
  Blue Cross and Blue Shield of Texas
  P. O. Box 660044
  Dallas, Texas 75266-0044

  An appeals form is included as Appendix B

- The Claim Administrator will honor telephone requests for information. However, such inquiries will not constitute a request for review.

- In support of your claim review, you have the option of presenting evidence and testimony to the Claim Administrator. You and your authorized representative may ask to review your file and any relevant documents and may submit written issues, comments and additional medical information during the internal review process.

  The Claim Administrator will provide you or your authorized representative with any new or additional evidence or rationale and any other information and documents used in the internal review of your claim without regard to whether such information was considered in the initial determination. No deference will be given to the initial Adverse Benefit Determination. Such new or additional evidence or rationale will be provided to you or your authorized representative sufficiently in advance of the date a final decision on appeal is made in order to give you a chance to respond before the final determination is made. If the information is received so late that it would be impossible to provide it to you in time for you to have a reasonable opportunity to respond, the time periods below for providing notice of Final Internal Adverse Benefit Determination will be tolled until such time as you have had a reasonable opportunity to respond. After you respond, or have had a reasonable opportunity to respond but failed to do so, the Claim Administrator will notify you of the benefit determination in a reasonably prompt time taking into account the medical exigencies.

  The appeal determination will be made by the Claim Administrator or, if required by a Physician associated or contracted with the Claim Administrator and/or by external advisors, but who were not involved in making the initial denial of your claim. Before you or your authorized representative may bring any action to recover benefits you must exhaust the appeal process and must raise all issues with respect to a claim and must file an appeal or appeals and the appeals must be finally decided by the Claim Administrator and, if applicable, your Employer.

- If you have any questions about the claims procedures or the review procedure, write to the Claim Administrator's Administrative Office or call the toll-free Customer Service Helpline number shown in this Benefit Booklet or on your Identification Card.

Timing of Appeal Determinations

Upon receipt of a non-urgent pre-service appeal, the Claim Administrator shall render a determination of the appeal as soon as practical, but in no event more than 30 days after the appeal has been received by the Claim Administrator.

Upon receipt of a non-urgent post-service appeal, the Claim Administrator shall render a determination of the appeal as soon as practical, but in no event more than 60 days after the appeal has been received by the Claim Administrator.

Notice of Appeal Determination

The Claim Administrator will notify the party filing the appeal, you, and, if a clinical appeal, any health care provider who recommended the services involved in the appeal, by a written notice of the determination.

The written notice to you or your authorized representative will include:

1. A reason for the determination;
2. A reference to the benefit Plan provisions on which the determination is based, and the contractual, administrative or protocol for the determination;
3. Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Diagnosis/treatment codes with their meanings and the standards used are also available upon request;
4. In certain situations, a statement in non-English language(s) that written notice of claim denials and certain other benefit information may be available (upon request) in such non-English language(s);
5. In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by the Claim Administrator;
6. The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
7. Any internal rule, guideline, protocol or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
8. An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request;
9. A description of the standard that was used in denying the claim and a discussion of the decision;
10. Contact information for applicable office of health insurance consumer assistance or ombudsman.

If the Claim Administrator's or, if applicable, your Employer's decision is to continue to deny or partially deny your claim or you do not receive timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision. Your external review rights are described in the **Standard External Review** section below.

If You Need Assistance

If you have any questions about the claims procedures or the review procedure, write or call the Claim Administrator Headquarters at 1-800-521-2227. The Claim Administrator Customer Service Helpline is accessible from 8:00 A.M. to 8:00 P.M., Monday through Friday.

Claim Review Section
Blue Cross and Blue Shield of Texas
P. O. Box 660044
Dallas, Texas 75266-0044

If you need assistance with the internal claims and appeals or the external review processes that are described below, you may call the number on the back of your ID card for contact information. In addition, for questions about your appeal rights or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

Standard External Review

You or your authorized representative (as described above) may make a request for a standard external review or expedited external review of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination by an Independent Review Organization (IRO).

1. **Request for external review.** Within four months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination from the Claim Administrator, you or your authorized representative must file your request for standard external review.
2. **Preliminary review.** Within five business days following the date of receipt of the external review request, the Claim Administrator must complete a preliminary review of the request to determine whether:
   a. You are, or were, covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the plan at the time the health care item or service was provided;

   b. The Adverse Benefit Determination or the Final Adverse Internal Benefit Determination does not relate to your failure to meet the requirements for eligibility under the terms of the plan (e.g., worker classification or similar determination);

   c. You have exhausted the Claim Administrator's internal appeal process unless you are not required to exhaust the internal appeals process under the interim final regulations. Please read the **Exhaustion** section below for additional information and exhaustion of the internal appeal process; and

   d. You or your authorized representative have provided all the information and forms required to process an external review.

   You will be notified within one business day after we complete the preliminary review if your request is eligible or if further information or documents are needed. You will have the remainder of the four month external review request period (or 48 hours following receipt of the notice), whichever is later, to perfect the request for external review. If your claim is not eligible for external review, we will outline the reasons it is ineligible in the notice, and provide contact information for the Department of Labor's Employee Benefits Security Administration (toll-free number 1-866-444-EBSA (3272)).

   External Review is available for Adverse Benefit Determinations and Final Adverse Benefit Determinations that involve rescission and determinations that involve medical judgment including, but not limited to, those based on requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or a covered benefit; determinations that a treatment is experimental or investigational; determinations whether you are entitled to a reasonable alternative standard for a reward under a wellness program; or a determination of compliance with the nonquantitative treatment limitation provisions of the Mental Health Parity and Addiction Equity Act.

3. **Referral to Independent Review Organization (IRO).** When an eligible request for external review is completed within the time period allowed, the Claim Administrator will assign the matter to an IRO. The IRO assigned will be accredited by URAC or by similar nationally-recognized accrediting organization. Moreover, the Claim Administrator will ensure that the IRO is unbiased and independent. Accordingly, the Claim Administrator must contract with at least three IROs for assignments under the plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

   The IRO must provide the following:

   a. Utilization of legal experts where appropriate to make coverage determinations under the plan.

   b. Timely notification to you or your authorized representative, in writing, of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the

assigned IRO within 10 business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.

c. Within five business days after the date of assignment of the IRO, the Claim Administrator must provide to the assigned IRO the documents and any information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Failure by the Claim Administrator to timely provide the documents and information must not delay the conduct of the external review. If the Claim Administrator fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Within one business day after making the decision, the IRO must notify the Claim Administrator and you or your authorized representative.

d. Upon receipt of any information submitted by you or your authorized representative, the assigned IRO must within one business day forward the information to the Claim Administrator. Upon receipt of any such information, the Claim Administrator may reconsider the Adverse Benefit Determination or Final Internal Adverse Benefit Determination that is the subject of the external review. Reconsideration by the Claim Administrator must not delay the external review. The external review may be terminated as a result of the reconsideration only if the Claim Administrator decides, upon completion of its reconsideration, to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination and provide coverage or payment. Within one business day after making such a decision, the Claim Administrator must provide written notice of its decision to you and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the Claim Administrator.

e. Review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Claim Administrator's internal claims and appeals process. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

   (1) Your medical records;
   (2) The attending health care professional's recommendation;
   (3) Reports from appropriate health care professionals and other documents submitted by the Claim Administrator, you, or your treating provider;
   (4) The terms of your plan to ensure that the IRO's decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law;
   (5) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
   (6) Any applicable clinical review criteria developed and used by the Claim Administrator, unless the criteria are inconsistent with the terms of the plan or with applicable law; and
   (7) The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

f. Written notice of the final external review decision must be provided within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to the Claim Administrator and you or your authorized representative.

g. The notice of final external review decision will contain:

   (1) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);

(2) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(3) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

(4) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(5) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Claim Administrator or you or your authorized representative;

(6) A statement that judicial review may be available to you or your authorized representative; and

(7) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

h. After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the Claim Administrator, State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws, and you or your authorized representative.

4. **Reversal of plan's decision.** Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Claim Administrator must immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review

1. **Request for expedited external review.** You may request for an expedited external review with the Claim Administrator at the time you receive:

   a. An Adverse Benefit Determination, if the Adverse Benefit Determination involved a medical condition of yours for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

   b. A Final Internal Adverse Benefit Determination, if the determination involved a medical condition of yours for which the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

2. **Preliminary review.** Immediately upon receipt of the request for expedited external review, the Claim Administrator must determine whether the request meets the reviewability requirements set forth in the **Standard External Review** section above. The Claim Administrator must immediately send you a notice of its eligibility determination that meets the requirements set forth in **Standard External Review** section above.

3. **Referral to Independent Review Organization (IRO).** Upon a determination that a request is eligible for external review following the preliminary review, the Claim Administrator will assign an IRO pursuant to the requirements set forth in the **Standard External Review** section above. The Claim Administrator must provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

   The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the Claim Administrator's internal claims and appeals process.

4. **Notice of final external review decision.** The assigned IRO will provide notice of the final external review decision, in accordance with the requirements set forth in the **Standard External Review** section above, as

expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing verbal notice, the assigned IRO must provide written confirmation of the decision to the Claim Administrator and you or your authorized representative.

Exhaustion

For standard internal review, you have the right to request external review once the internal review process has been completed and you have received the Final Internal Adverse Benefit Determination. For expedited internal review, you may request external review simultaneously with the request for expedited internal review. The IRO will determine whether or not your request is appropriate for expedited external review or if the expedited internal review process must be completed before external review may be requested.

You will be deemed to have exhausted the internal review process and may request external review if the Claim Administrator waives the internal review process or the Claim Administrator has failed to comply with the internal claims and appeals process.

The internal review process will not be deemed exhausted based on *de minimis* violations that do not cause, and are not likely to cause, prejudice or harm to you so long as the Claim Administrator demonstrates that the violation was for good cause or due to matters beyond the control of the Claim Administrator and that the violation occurred in the context of an ongoing, good faith exchange of information between you and the Claim Administrator.

External review may not be requested for an Adverse Benefit Determination involving a claim for benefits for a health care service that you have already received until the internal review process has been exhausted.

Interpretation of Employer's Plan Provisions

The Plan Administrator has given the Claim Administrator the initial authority to establish or construe the terms and conditions of the Health Benefit Plan and the discretion to interpret and determine benefits in accordance with the Health Benefit Plan's provisions.

The Plan Administrator has all powers and authority necessary or appropriate to control and manage the operation and administration of the Health Benefit Plan.

All powers to be exercised by the Claim Administrator or the Plan Administrator shall be exercised in a non-discriminatory manner and shall be applied uniformly to assure similar treatment to persons in similar circumstances.

BlueCross BlueShield of Texas

Claim Review Form

This form is only to be used for review of a previously adjudicated claim. Original Claims should not be attached to a review form. Do not use this form to submit a Corrected Claim or to respond to an Additional Information request from BCBSTX. Submit only one form per patient.

*****Inquiries received without the required information below may not be reviewed.*****

Claim Number:	**(For multiple claims provide the additional claim number below)**	
Group Number:	Prefix (3 character alpha):	Member Identification Number:
Patient Name: (Last, First)		
Date(s) of Service:	Total Billed Amount:	
Provider Name:	NPI:	
Contact Person:	Phone Number:	
Provide detailed information about your review request, including additional claim numbers, if applicable. Attach supporting documentation, if necessary.		

REMINDERS

- **Mail inquiries to:** Blue Cross and Blue Shield of Texas
  P.O. Box 660044
  Dallas, TX 75266-0044
- **Additional Information requests** – If you received an Additional Information request from BCBSTX, follow the instructions provided and use that letter as the cover sheet. If you do not have the cover sheet please use the Additional Information Form located at bcbstx.com/provider. *Examples of additional information include, but aren't limited to: Medical Records, Operative Reports, Coordination of Benefits, Medicare Explanation of Benefits, etc.*
- **Corrected Claim requests** should be submitted as electronic replacement claims, or on a paper claim form along with a Corrected Claim Review Form available on our website at bcbstx.com/provider.

To submit Claim Review requests online utilize the Claim Inquiry Resolution tool, accessible through Electronic Refund Management (ERM) on the Availity™ Web Portal at *availity.com*.