Anthem Blue Cross and Blue Shield
Healthy Indiana Plan

CHAPTER 9: PROVIDER GRIEVANCES AND APPEALS

PROVIDER GRIEVANCES AND APPEALS

Physician Appeals Process For Indiana

Anthem encourages you to seek resolution of issues through the provider complaint and appeal process. Designed to provide appropriate and timely review when you disagree with an Anthem decision, these procedures meet requirements of state laws and accreditation agencies.

The building blocks of this process are the complaint and the appeal. A complaint is any expression of dissatisfaction to Anthem by a provider. Initial requests for Anthem to change a previous decision other than an adverse utilization management decision will be handled exclusively as complaints. For some issues, the complaint is the only level of review available. An appeal is a formal request for Anthem to change a decision upheld by Anthem through the complaint process, or, in the case of an adverse utilization management decision, a request by a provider for Anthem to change that decision.

How Operational Issues Are Handled

Operational complaints and appeals can be submitted in writing to Anthem’s Provider Inquiry Department. Examples of operational issues include claim processing, benefit interpretation and reimbursement. For most issues involving reimbursement, the complaint is the only level of review. For other operational issues, a standard appeal (single level of review) is offered if the physician is not satisfied with the response to the complaint.
CHAPTER 9: PROVIDER GRIEVANCES AND APPEALS

How Clinical Issues Are Handled

Clinical appeals are requests to change decisions based on whether services or supplies are medically necessary or experimental/investigative. Utilization Management program clinical appeals involve certification decisions evaluated on these bases. Non-Utilization Management program clinical issues include claims or predetermination decisions evaluated on these bases. For clinical issues, there are two (2) types of reviews – standard and expedited. Anthem offers an expedited appeal for decisions involving urgently needed care. Both standard and expedited appeals are reviewed by a person who is not the subordinate of the initial decision-maker.

Prospective Clinical Issues

When a physician or provider expresses dissatisfaction about an adverse Utilization Management program decision involving a clinical issue, the case is automatically handled as an appeal or a reconsideration rather than a complaint.

A reconsideration is when Anthem, upon request by a treating physician, reevaluates the initial determination. Reconsiderations are handled outside of the appeals process and in accordance with Anthem Utilization Management policies.

A standard appeal is available following the reconsideration, or initially if a reconsideration is not requested in a timely manner. An expedited appeal is available for urgently needed care. A standard appeal is available following an expedited appeal, except for appeals involving Kentucky members. Anthem’s Utilization Management Department communicates utilization management program clinical decisions to physicians. This communication includes notice of the physician’s appeal rights.

Time Frames for Submitting Complaints and Appeals

A grievance may be filed up to 60 calendar days of the date the provider became aware of the issue.

Appeals may be filed up to 30 calendar days of the date of the notice of action letter advising of the adverse determination.
CHAPTER 9: PROVIDER GRIEVANCES AND APPEALS

How Special Complaints and Appeals Are Handled

Certain types of complaints or appeals are handled by specific Anthem departments and may follow different policies and procedures. The following is a brief summary of some special complaints and appeals procedures.

Receipt and Acknowledgement of Grievance or Appeal

The Plan will send a written acknowledgement to the provider within 5 calendar days of receiving a provider grievance or appeal.

If the provider submits a request for an expedited appeal, it is treated as a member appeal. See the Member Grievances and Appeals chapter.

Requesting More Information

The Plan may request, by telephone or fax, medical records or a provider explanation of the issues raised in the grievance or appeal received by the Plan.

- For grievances or appeals, providers must comply with the request within 10 working days of the date that appears on the request.
- For expedited appeals, providers must comply with the request within 24 hours of the date of our request for information.

When to Expect Resolution for a Grievance or Appeal

For provider grievances, the Plan sends a written resolution letter to the provider within 30 calendar days of the receipt of the grievance.

For provider post-service appeals, the Plan sends a resolution letter to the provider within 30 calendar days of receipt of the appeal. The resolution letter also provides details on further appeal rights.
According to state law, there are certain grievances that the Plan may not be able to inform the provider of the final disposition. In cases where the Plan has investigated a provider, and in cases related to quality of care, the Plan notifies the provider that the grievance was received and investigated, and further informs the provider that the final disposition cannot be provided due to peer confidentiality.

For More Information

Questions concerning the complaint and appeals process can be directed to the Provider Inquiry Department at 800-345-4344 or your Provider Relations/Network Management representative.

How Providers File a Grievance or Appeal

Providers may file a grievance in writing to the Utilization Management (UM) department:

ATTN: Utilization Management Appeals
Anthem Blue Cross and Blue Shield
P.O. Box 37220
Louisville, KY 40232-7220

For non-utilization appeals, providers may file a grievance in writing to Grievance and Appeals.

ATTN: Grievance & Appeals
Anthem Blue Cross and Blue Shield
P.O. Box 33200
Louisville, KY 40232-3200

Or the provider can submit a grievance by faxing a Provider Appeal Form to 417-888-9005.
CHAPTER 9: PROVIDER GRIEVANCES AND APPEALS

Grievance and Appeals Phone number: 800-325-3377

Click the following link to print a Provider Appeal Form.

Contact Information

For questions related to grievances or appeals, contact:

Provider Inquiry
• Anthem Healthy Indiana Plan: 800-345-4344

Utilization Management
• Anthem Healthy Indiana Plan: 866-398-1992

Grievances & Appeals (Non-Utilization Management)
• Anthem Healthy Indiana Plan: 800-325-3377