

Guide to Provider Complaints and Appeals

Based on feedback from providers, Anthem Blue Cross and Blue Shield (Anthem) is clarifying our guidelines for submitting provider complaints and appeals for disputes relating to claim payment and benefit determinations. Anthem also is introducing a checklist to assist you in submitting such requests. This information applies to providers rendering services to local and BlueCard® commercial members. Guidance for Federal Employee Program (FEP) and Medicare Advantage members is also included at the end of this document.

We encourage you to seek resolution of issues by using the provider complaint and appeal process outlined in detail in the provider manual, available on our website at www.anthem.com. The provider complaint and appeal process is designed to provide appropriate and timely review when providers disagree with a decision made by Anthem. The procedures also meet requirements of state laws and accreditation agencies.

The building blocks of Anthem’s provider complaint and appeal process are the **complaint** and the **appeal**.

- A **complaint** is any expression of dissatisfaction submitted to Anthem by a provider concerning claim payment or member benefits. In most instances, an initial request for Anthem to change a previous decision, other than an adverse Utilization Management (UM) decision, will be handled exclusively as a complaint. 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 UM decision, a request by a provider for Anthem to change that decision.

Membership Definitions

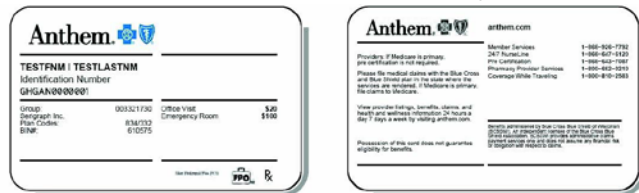
Local Anthem Members -- These are members who are either insured by, or have benefit administration (self-funded accounts) performed by, Anthem. You can recognize these members by the Anthem logo on the front of the member identification card and/or tagline appearing on the bottom right corner on the back of the card, as indicated in the examples below.

- If the member is insured by Anthem, the tagline on the back of the member identification card will hold a statement that notifies all of the risk bearing Anthem Plan.
- If the member is part of a self-funded (administrative services only) group, the tagline will indicate that “benefits are administered by...”

Example – Fully insured local member



Example – Administrative services only member



BlueCard® Members -- BlueCard® is a program that links health care providers and the independent Blue Cross and Blue Shield Plans across the country and around the world through a single electronic network for claims processing reimbursement. Contracted providers “host” or render services to Blue Plan members that are not insured or administered by your local Anthem Plan. Your local Anthem Plan is responsible for pricing according to the terms of your contract and remitting payment to you. Your local Anthem Plan is your single point of contact for issues related to BlueCard members. The member’s Home (the Blue Plan insuring or administering benefits) Plan determines the benefits and rules such as medical necessity and sends the member an explanation of benefits (EOB).

You can recognize BlueCard[®] members by the logo and tagline appearing on the member's identification card. The member's Blue Plan will be identified next to the BlueCross BlueShield logo and in the taglines appearing on the back of the card, as indicated in the standardized card example below. All Blue plans use this standardized format.

Example – Member insured or administered by a non-Anthem Blue plan

 BlueCross BlueShield of Geography		Blue Product	ALPHA Employer Group
Member Name Member Name Member ID XYZ123456789	Dependents Dependent One Dependent Two Dependent Three		
Group No. 023457 BIN 987654 Benefit Plan HIOPT Effective Date 09/00/00 Plan Code 123	Plan PPO Office Visit \$15 Specialist Copy \$15 Emergency \$75 Deductible \$50		
			

 BlueCross BlueShield of Geography	www.BluePlan.com Customer Service: 1-800-234-5678 Outside of Area: 1-800-810-2583 Eligibility: 1-800-676-2883 Pharmacy Benefits: 1-800-123-4567 Alpha Visor [®] : 1-800-987-6543 *Not a Blue Cross Blue Shield product
Members: See your benefit booklet for covered services. Possession of this card does not guarantee eligibility for benefits. Hospital or physicians: file claims with local BlueCross and/or BlueShield Plan. BlueCross and BlueShield of Geography provides administrative services only and does not assume any financial risk for claims.	BlueCross and BlueShield of Geography P.O. Box 01234 City, State 01234-1234 An independent licensee of the BlueCross and BlueShield Association.
BETA Pharmacy Management	

Complaints

Local Anthem Members

Administrative issues or operational complaints can be submitted to Anthem's customer/provider service department in one of the following ways:

- Contact the customer/provider service phone number on the member's identification card, or
- Submit a completed Provider Adjustment form (available on our public provider website at www.anthem.com), or
- Send a Secure Message via the Availity[®] multi-payer portal.

Examples of administrative or operational issues include claim processing, benefit interpretation and reimbursement. For most **issues involving reimbursement, the complaint is the only level of review**. For other administrative issues or operational complaints, a standard appeal (single level of review) may be offered if the provider is not satisfied with the response to the complaint. Decisions to terminate or non-renew a provider contract are not "complaints" for purposes of this Guide and are not subject to appeal rights except as expressly set forth in a provider agreement.

BlueCard[®] Members

Complaints are expressions of dissatisfaction that are **not related** to medical necessity, experimental/investigative and/or UM decisions involving precertification/predetermination. Examples of provider complaints include but are not limited to: claims denied for untimely filing, Anthem contractual reimbursement (i.e. pricing), Anthem clinical claim edits (i.e. code bundling). A physician or other provider who expresses dissatisfaction, and wishes to file a complaint, may do so in one of the following ways:

- Contact the customer/provider service phone number on the member's identification card, or
- Submit a completed Provider Adjustment form (available on our public provider website at www.anthem.com), or
- Send a Secure Message via the Availity[®] multi-payer portal.

If submitting a Provider Adjustment form, please attach supporting documentation and send it to your local Anthem Plan at the address specified on the form instructions page. Your local Anthem Plan will image and forward this information, as needed, to the member's Home Plan and notify you of the decision. The Provider Adjustment form and instructions are available on our public provider website at www.anthem.com.

Status: If your complaint was submitted on a Provider Adjustment form, you can check status by contacting customer/provider service. If your complaint was submitted Secure Message, a response will be sent to your secure message inbox.

Appeals

Local Anthem Members

Clinical appeals are requests to change decisions based on whether services or supplies are **medically necessary** or **experimental/ investigative**. UM program clinical appeals involve **certification decisions**, claims or predetermination decisions evaluated on these bases.

For clinical issues, there are two (2) types of review: standard and expedited. Anthem offers an expedited appeal for decisions meeting the expedited criteria. Please note: Requests to handle a review as “expedited” are always handled as a member appeal. Both standard and expedited appeals are reviewed by a person who did not make the initial decision.

When a physician or other provider expresses dissatisfaction about an adverse UM program decision involving a clinical issue, the issue can be handled as an appeal if the physician/provider formally requests an appeal or reconsideration instead of submitting a complaint. UM decisions are communicated in writing to the provider and member. These letters provide details on appeal rights and the address to use when sending additional information. Reconsideration is when Anthem, upon request by a treating physician, re-evaluates the initial determination. Reconsiderations are handled outside of the appeals process and in accordance with Anthem UM policies.

A standard appeal is available following the reconsideration, or initially, if it is formally requested. Please note: Requests for appeal of pre-service requests will always be handled as a member appeal. An expedited appeal is available for cases meeting the expedited criteria. Please see the instructions detailed in the UM decision letter.

Appeals following a complaint should be submitted to Anthem in writing, along with a copy of our response to the original complaint. Send the appeal request to:

Anthem Blue Cross and Blue Shield
PO Box 105568
Atlanta, GA 30348-5568

To help ensure that we receive all the necessary information to act on your appeal, please use the [Provider Appeal Checklist](#). This document is located at [anthem.com>Provider \(enter state\)>Answers at Anthem](#).

BlueCard® Members

Appeals involving clinical decisions related to **medical necessity, experimental/investigative** and/or **Utilization Management (UM)** decisions involving precertification/predetermination are the **responsibility of the Blue Plan insuring or administering benefits** for non-Anthem members.

Technically the member, not the provider, is responsible for obtaining the necessary authorization prior to the delivery of non-inpatient admission services. We understand that many providers obtain prior authorization or may wish to dispute these types of denials on behalf of, and as a service to, their patients.

- If your appeal relates to precertification/predetermination, you may have **received information directly from the member’s Home Plan** regarding appeal rights and processes. Please **follow the directions provided** by the member’s Home Plan.
- If you **did not receive this information from the member’s Home Plan** and wish to appeal a **medical necessity or experimental/investigational** claim denial, your local Anthem Plan is your point of contact. When a physician or provider expresses dissatisfaction and wishes to file an appeal as indicated in the description above, a completed Provider Adjustment form should be submitted, along with attached supporting documentation, to your local Anthem Plan at the address specified on the instructions page.

Send the appeal request to:

Anthem Blue Cross and Blue Shield
PO Box 105557
Atlanta, GA 30348

Your local Anthem Plan will image and forward this information, as needed, to the member’s Home Plan for consideration and **notify you of the decision**. The Provider Adjustment form and instructions are available at [www.anthem.com](#).

Guidance for Other Programs

Federal Employee Program® (FEP®) Members

- On the FEP member ID card, the member ID always starts with “R,” followed by 8 digits.
- The appeal must be in writing and must be received within 180 days of the initial adverse action.
- If the provider is incapable of submitting a written appeal, the provider may submit a verbal request, which must be received within 180 days of the initial adverse action.
- The appeal must be submitted by the performing provider.
- The appeal must be for reconsideration of our payment/final denial of a claim.
- The claim determination must be final (no request for additional information, request for treatment plan, etc.).
- The claim determination cannot hold the provider harmless.
- Only clinical denials (such as not medically necessary, experimental and investigational, when the amounts are provider liability) are eligible for the provider appeal process. Administrative denials (such as timely filing) are not eligible for the provider appeal process and should be handled by customer service.
- The request must include member identification number, date(s) of service, claim number(s), reason for the appeal, and any written comments, documents, records, or other information relating to the case.
- The Plan’s decision is due within 30 calendar days from receipt of the appeal request. If additional records are required, the Plan has an additional 60 days to obtain this information.

For additional questions on these guidelines, please contact the appropriate FEP customer service center for your state: Indiana 800-382-5520; Kentucky 800-456-3967; Missouri 800-392-8043; Ohio 800-451-7602 or Wisconsin 800-242-9635.

Send a **clinical** appeal request to:

Anthem Blue Cross and Blue Shield
Federal Employee Program
ATTN: PROVIDER APPEALS UNIT
1351 William Howard Taft Road
Cincinnati, OH 45206

Send a **non-clinical** appeal request to:

Anthem Blue Cross and Blue Shield
PO Box 105557
Atlanta, GA 30348

Anthem Medicare Advantage Plans: Anthem MediBlue Access (PPO), Anthem MediBlue Plus (HMO) and Anthem MediBlue Dual Advantage (HMO SNP)

Information on the requirements and process for appeals and complaints can be found in the Medicare Advantage HMO and PPO Provider Guidebook on our public website at www.anthem.com/medicareprovider. Please note that these products are not available in all states or counties within a state.

Questions

If there are questions, please contact customer/provider service at the telephone numbers published on this site for your state, under Contact Us. If you are not certain whether your situation should be expressed as a complaint or an appeal, please contact customer/provider service or your local Network Relations Consultant.