Complaints and Appeals

The Grievances and Appeals Unit (GAU) is here to provide a thorough, timely, and unbiased review of complaints, and administrative and medical appeals. The purpose of this process is to ensure that benefits are administered equitably according to member contracts, regulatory mandates, accrediting standards, and Blue Cross policies. This process will ensure that objective, equitable outcomes are achieved.

Complaints and Administrative Appeals

A **complaint** is a verbal (spoken) or written expression of dissatisfaction to review a circumstance which makes you unhappy, including but not limited to dissatisfaction with a benefit or coverage decision, customer service, or the quality or availability of a health service.

An **administrative appeal** is a verbal or written request for us to reconsider (make another decision about) a full or partial denial of payment or a request for us to reconsider an adverse decision that affects your ability to receive benefit coverage, access to care, access to services, or any unresolved complaints.

We will let you know in writing or by phone that we received your complaint or administrative appeal within 10 business days. The GAU will conduct a complete review of your complaint or administrative appeal and respond in the time frames below.

Administrative Complaints

We will respond to your **complaint** in writing within 30 calendar days of the date we receive it. Our response for administrative complaints will provide you with the results of our investigation into your complaint and information on the next steps available to you.

Quality of Care Complaints

The Quality Management department will respond to your quality of care complaint in writing within 30 calendar days of the date it is received into the organization and provide you with information on the additional steps available to you. We review all relevant information concerning your quality of care concern, including your statement as well as information submitted by the provider. We may contact you by phone or in writing to obtain clarification or additional information regarding your quality of care concern. Your complaint with all the pertinent information is then presented to our Medical Director for consideration and determination. If a finding identifies a quality of care issue, it is presented to the provider for corrective action(s).

Administrative Appeals

If you wish to file an **administrative appeal**, you must do so within 180 days of receiving a denial of benefits. We'll respond to your administrative appeal in writing within 60 calendar days of receiving it. The letter with our decision will provide information about why that decision was made and information on the next steps available to you. Please refer to the Judicial Review section below for additional information.

Medical Appeals

A **Medical Denial** is a decision by Blue Cross not to reimburse or pay you or a provider either partially or fully, for a specific request or claim for services on the basis that the services were not medically necessary, appropriate, or were available in the Blue Cross network.

An **appeal** is a verbal or written request for us to reconsider a full or partial medical or benefit denial.

If we deny payment for a service for medical reasons, you'll receive the denial in writing. The written denial you receive from us will explain the reason for the denial and provide specific instructions for the medical appeals process.

Level 1 Review

You may request a Level 1 review of any matter that is subject to medical appeal by making a request (preferably in writing) for such a review to Blue Cross within 180 calendar days of the initial decision letter.

You will receive written notification of the decision on a Level 1 pre-service review within 15 calendar days of receipt of the medical appeal request. If you are requesting reconsideration (Level 1 review) of a service that was denied after you already obtained the service (retrospectively), you will receive written notification of our decision within 15 business days of our receipt of the appeal.

Level 2 Review – Applicable only to members with employer group coverage

You may request a Level 2 appeal review (preferably in writing) if our denial was upheld during the Level 1 review process. Your Level 2 appeal review will be reviewed by a provider in the same specialty as your treating provider. You must submit your request for a Level 2 appeal review within 180 calendar days of the date of the reconsideration decision letter. Upon request for a Level 2 review, Blue Cross will provide you with the opportunity to inspect the medical file and add information to the file.

You will receive written notification of the decision on a Level 2 pre-service review within 15 calendar days of the appeal request. If the service you are requesting review of was denied after you already obtained the service (retrospectively), you will receive written notification of our decision within 15 business days of our receipt of the appeal request.

Note: You may request an expedited (faster) review of denied services if the circumstances are urgent or if you are in an inpatient setting. You or your doctor must call the GAU at (401) 459-5784 or 1-800-639-2227 or fax your request to (401) 459-5005. An expedited decision will be made within two business days or 72 hours, whichever is shorter, following receipt of the request, or sooner if the urgent nature of the circumstances require and it is reasonably possible to make such a decision in a shorter period of time. Members in urgent situations and while receiving an ongoing course of treatment may proceed with expedited external review at the same time as the internal appeals process.

External Appeal – Available to members with employer group coverage after the second level appeal denial. Available to members with individual coverage after the first level appeal denial.

If you remain dissatisfied with the decision of Blue Cross's internal review (Level 1 and Level 2) processes, you may request an external review by an outside review agency. An external appeal is a complete reexamination of your case by an independent review organization (IRO). For members covered by group health plans, this external appeal is a voluntary level of appeal. This means that you may choose to participate in this level of appeal, or you may file suit in an appropriate court of law (see Judicial Review).

To request an external review, you must submit your request in writing to Blue Cross within four months of your receipt of the medical appeal denial notification. Members are not required to bear any costs when requesting that a case be sent for external review to an IRO. Blue Cross will forward your letter and the entire case file to the IRO within five business days, or two business days for an expedited appeal. Upon receipt of the necessary information, the IRO will notify you of the result of your appeal within 10 business days, or two business days for an expedited appeal. If the IRO overturns our decision, we will authorize or pay for the services in question.

Judicial Review

If you are dissatisfied with the final decision of the IRO, you are entitled to a final review (a Judicial Review). This review will take place in an appropriate court of law.

For members covered by group health plans, you have the right to bring a civil action following an adverse benefit determination on review pursuant to section 502(a) of the Employee Retirement Income Security Act of 1974. For these members, you may bring such action either after your appeal is decided for administrative appeals, or prior to the external review level for medical appeals.

Note: At any time, you may request copies of your case file (free of charge) by contacting us at the telephone number(s) listed above or in your decision letter.

How to File Any Complaint or Appeal

If you're unhappy with any aspect of our operation, the quality of care you have received, or you have a request for us to reconsider a full or partial denial of services or benefits, please call Customer Service at the number on the back of your member ID card. A customer service representative will log your inquiry and try to resolve your concern.

If your concern is not resolved to your satisfaction, you may file a complaint or appeal verbally with the customer service representative.

You may also file a complaint or appeal in writing. To do so, you must provide all of the information below:

- Your name, address, and member ID number
- A summary of the complaint or appeal, any previous contact with Blue Cross, and a brief description of the relief or solution you are seeking
- Any additional information such as referral forms, claims, or any other documentation that you would like us to review
- The date of the incident or service
- Your signature, if sending in writing

If someone is filing a complaint or any appeal for you, you must designate (name) someone other than your healthcare provider to represent you in your appeal. Blue Cross requires a signed, written request from you authorizing that person to act on your behalf.

Please mail the complaint or appeal to:

Attention: Grievances and Appeals Unit
Blue Cross & Blue Shield of Rhode Island
500 Exchange Street
Providence, RI 02903