Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Transitioning the inpatient admission appeal process to Grievance and Appeals

Frequently asked questions for providers

For Medicare Plus Blue℠ and BCN Advantage℠

Revised January 2026

In this document

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As previously communicated, on Dec. 22, 2025, we transitioned the inpatient admission appeal process to our Medicare Plus Blue and BCN Advantage Grievance and Appeals units. As a result of this change, the provider has the right to appeal on behalf of the member for all denied inpatient admissions. This means the provider and the member have the same appeal rights for all adverse decisions.

Note: This change applies only to appeals related to adverse determinations of acute inpatient medical / surgical and behavioral health admissions for Medicare Plus Blue and BCN Advantage members. Blue Cross and BCN commercial members are not included.

In this document, you'll find answers to frequently asked questions about this change.

General information

Which providers does this change affect?

Hospitals and facilities that submit appeals related to acute inpatient medical / surgical and behavioral health admissions for Medicare Plus Blue and BCN Advantage members are affected by this change.

Does this change only impact Medicare Advantage?

Yes. This change only affects appeals related to acute inpatient medical / surgical and behavioral health admissions for Medicare Plus Blue and BCN Advantage members.

Note: This change doesn't impact Blue Cross or BCN commercial members or appeals submitted on their behalf.

Which appeal types are part of this change?

Appeals of pre-service, concurrent, and retrospective (post-service) authorization requests of medical / surgical and behavioral health admissions for Medicare Plus Blue and BCN Advantage members are part of this change.

Are pre-claim and post-claim appeals part of this change?

No. Appeals related to disputes for reimbursement aren't part of this change.

What's changing?

Key changes are outlined in the table below.

Prior to Dec. 22, 2025	Starting Dec. 22, 2025
The appeal follows the two-level provider appeal process managed by Blue Cross and BCN Utilization Management.	Appeals of denied inpatient admissions follow the five-level member appeal process defined by the Centers for Medicare & Medicaid Services.
Appeals are submitted through the e-referral system.	Appeals are submitted to the appropriate Grievance and Appeals unit by fax or by mail.
The provider and the member follow separate appeal processes.	Providers have the right to appeal on behalf of the member for all denied acute inpatient admissions. This means the provider and the member have the same appeal rights for all adverse decisions.

When does this change start?

As we transition the inpatient appeal process to Grievance and Appeals, you should be aware of the following dates:

	For denials issued prior to Dec. 22, 2025	For denials issued on or after Dec. 22, 2025
Type of appeal	The appeal will follow the two-level provider appeal process.	• The provider can appeal on behalf of the member. • The appeal will follow the five-level member appeal process defined by the Centers for Medicare & Medicaid Services.
Last day to submit an appeal	Providers can submit appeals through the e-referral system until Dec. 31, 2025. **Important**: All appeals must be submitted by Dec. 31, as this is the last day for the two-level provider appeal process.	NA

	For denials issued prior to Dec. 22, 2025	For denials issued on or after Dec. 22, 2025
Medicare Plus Blue	Submit the appeal in one of the following ways: • Through the e-referral system • By fax: 1-877-495-3755 • By eFax: MedicarePlusBlueInpatientAppeals@bcbsm.com	Submit the appeal in one of the following ways: By mail: Blue Cross and Blue Shield of Michigan Medicare Advantage Grievances and Appeals Dept. P.O. Box 2627 Detroit, MI 48231-2627 By fax: 1-877-348-2251
BCN Advantage	Submit the appeal in one of the following ways: • Through the e-referral system • By fax: 1-866-522-7345	Submit the appeal in one of the following ways: By mail: BCN Advantage Appeals and Grievance Unit P.O. Box 44200 Detroit, MI 48244-0191 By fax: 1-866-522-7345

Grievance and Appeals

What is the five-level appeal process?

The five-level appeal process is described below. If an appeal is not resolved at one level, it proceeds or can proceed to the next.

Level	Description
Level 1	Blue Cross or BCN standard or fast appeal — If Blue Cross or BCN's denial is maintained, the appeal automatically proceeds to a level 2 review by the independent review organization.
Level 2	Review by an independent review organization — If the independent review organization maintains the denial, the provider or member can request a level 3 review by an Administrative Law Judge.
Level 3	Review by an Administrative Law Judge — This must be requested.

Level	Description
Level 4	Review by the Medicare Appeals Council — This must be requested.
Level 5	Review by federal district court — This must be requested.

How do I submit an appeal of a denied authorization request?

For any denied inpatient authorization issued on or after Dec. 22, 2025, you can submit an appeal to the appropriate Grievance and Appeals unit as outlined in the following table.

Coverage	How to submit the request
Medicare Plus Blue	Mail to: Blue Cross and Blue Shield of Michigan Medicare Advantage Grievances and Appeals Department P.O. Box 2627 Detroit, MI 48231-2627 Fax: 1-877- 348-2251
BCN Advantage	Mail to: BCN Advantage Appeals and Grievance Unit P.O. Box 44200 Detroit, MI 48244-0191 Fax: 1-866-522-7345

What is the timeframe for submitting an appeal?

You have the right to request an appeal within **65 calendar days** of the date of the denial notice. If you request an appeal after 65 days, you must explain why your appeal is late.

If I miss the submission deadline, can I still have my appeal reviewed?

Since the CMS guidelines for submitting late appeals are extremely limited, we strongly encourage providers to submit appeals on time. CMS views late appeal submissions from members and providers differently. CMS expects providers to read their appeal rights and follow the guidelines.

Note: Providers may be excused from meeting the submission timeframes defined by CMS in cases when extreme events, such as tornados, floods, or similar occurrences, make it out of their control to file timely. However, if submission is past the 65 calendar day timeframe, supporting evidence is required with the appeal.

What do I need to include with my appeal?

When submitting an appeal on behalf of a member, you'll get the fastest response by including the following:

- The member's *Integrated Denial Notice (IDN)* letter that was issued with the denial
- Contact information as it appears on the denial letter, including the contact's name, phone number, fax and email
- The member's name, date of birth, contract number (which is the member's identification number from their member ID card) and the date of the service you're appealing (the date of service should not include observation)
- The date the member presented to the hospital
- The date and time the member was admitted to inpatient status, including the documented physician inpatient order
- The reason for the denial, as was referenced in the denial letter
- The physician's and consult's rationale that supports medical necessity for the admission, which is outside of InterQual® criteria
- CPT codes, for a surgical admission
- The physician's discharge summary, if the member has been discharged

If a third-party vendor is submitting the appeal on behalf of the facility, the vendor must include the *Appointment of Representation (AOR)* form with the appeal request. We will accept a standard pre-service reconsideration for service from the member, the member's representative, the member's treating physician acting on behalf of the member, staff of a physician's office acting on the physician's behalf, or any other provider or entity determined to have an appealable interest in the proceeding.

Will I be notified that my appeal has been received?

For standard requests, Grievance and Appeals provides an acknowledgment letter by mail to the requestor of the appeal. For expedited appeals, acknowledgement is provided verbally.

How long does it take to receive a decision from Grievance and Appeals?

For expedited appeals, a decision will be made within 72 hours of receipt. For standard appeals, a decision will be made within 30 days of receipt. If the appeal decision is favorable, the plan will advise the member and the provider by phone and in writing. If the appeal is denied, the case will be forwarded to the independent review organization within the applicable processing timeframes.

Note: This time period can be extended by up to 14 calendar days if more information is needed to make a decision.

How long does it take to receive a decision from the independent review organization?

For expedited appeals, a decision will be made within 72 hours of receipt. For standard appeals, a decision will be made within 30 days of receipt. Once the independent review organization makes the decision, they will provide a written response of approval or denial. If the appeal is denied, the denial notice will include the directions to appeal to the Administrative Law Judge.

How do I contact the independent review organization?

The independent review organization will send acknowledgments and decisions directly to the member and the provider. The independent review organization doesn't have a direct contact number to check on appeal statuses.

Are there fees associated with an independent review?

There are no fees associated with a review by the independent review organization.

How do I check the status of an appeal?

For questions about an appeal that was submitted to Grievance and Appeals, call Provider Inquiry at one of the numbers below:

- Provider: 1-866-309-1719
- Facility: 1-800-249-5103
- Professional: 1-800-344-8525

How will determination letters be sent?

Determination letters will be sent by Grievance and Appeals by fax or by mail.

Do I need to complete an Appointment of Representative form to submit an appeal on behalf of a member?

An *AOR* is needed in these instances:

- If a provider is helping a member with an appeal past level 2, the provider needs to be appointed as the member's representative by completing an *AOR*.
- If a third-party vendor is submitting the appeal on behalf of the facility, the vendor must submit an *AOR* with the appeal request.

Additional information

Can appeals for Blue Cross and BCN commercial members still be submitted through the e-referral system?

The process of submitting appeals for Blue Cross and BCN commercial members isn't changing. Continue to submit appeals for Blue Cross and BCN commercial members through the e-referral system.

Are there plans to return to an electronic submission process?

Appeals must be submitted to Grievance and Appeals by fax or by mail. The technology and processes to submit appeals electronically continue to be reviewed. At this time, there is no date for implementation.

Where can I find more information about the appeal process?

For information about submitting appeals of denied authorization requests, refer to the pertinent provider manual, as follows:

- Medicare Plus Blue: Open the Medicare Plus Blue PPO Provider Manual. Look in the section titled "Appealing Medicare Plus Blue's Decision."
- BCN Advantage: Open the *BCN Provider Manual's* BCN Advantage chapter. Look in the section titled "BCN Advantage provider appeals."