Blue Cross Blue Shield Blue Care Network of Michigan

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

Provider alert

Medicare Plus Blue℠ and BCN Advantage℠

Category: Authorizations / referrals

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How to submit appeals of Medicare Advantage inpatient acute care admissions

Please submit appeals of denied authorization requests for Medicare Advantage inpatient acute care admissions (non-behavioral health) according to the process described in:

- The denial letter we send you
- Our provider manuals

Click to go directly to a section in this document:

- Medicare Plus Blue: Appeal process for inpatient acute care admissions
- BCN Advantage: Appeal process for inpatient acute care admissions

Medicare Plus Blue: Appeal process for inpatient acute care admissions

You'll find the process for submitting appeals of denied authorization requests for inpatient acute care admissions of Medicare Plus Blue members in the Medicare Plus Blue PPO Provider Manual.

Here's a snapshot from the section titled "Contracted MI Provider Acute Inpatient Admission Appeals."

Contracted MI Provider Acute Inpatient Admission Appeals

Appealing Medicare Plus Blue's Decision

All Michigan providers have the right to appeal an adverse medical decision made by Medicare Plus Blue Utilization Management. Denials of coverage related to medical necessity or medical appropriateness are made by the plan medical directors and are based on the following:

- Information from the attending physician
- Consideration of the member's benefit coverage
- Review of pertinent medical information
- Clinical judgment of the medical director

At any step in the appeal process a plan medical director may obtain the opinion of a same specialty, board certified physician or external review board.

How to request an appeal

Expedited Appeal - May be requested when circumstances require a decision be made in a short period of time because a delay may seriously jeopardize the life or health of the member. Retrospective requests will not be considered for expedited status. This decision is final and no other appeal option is available to the provider.

Requests can be made via phone by calling *1-866-807-4811*.

Medicare Plus Blue will notify the provider of the decision within 72 hours and the decision of an expedited appeal is final and there are no other appeal options available to the provider.

How to submit 1st and 2nd level appeal requests:

Fax request to: 1-877-495-3755

Or

Email to: MedicarePlusBlueInpatientAppeals@bcbsm.com

1st Level Appeal Filing Time Frames

Must be submitted **within 45 days of date of denial decision** on denial notification and requests must include additional clarifying clinical information to support the request.

Medicare Plus Blue will notify the provider of the decision **within 30 calendar days** of receiving all necessary information.

2nd Level Appeal Filing Time Frames

Must be submitted **within 21 days** from the date of the 1st level appeal decision. Must contain at least one of the following:

- New or clarifying information
- A clear statement of what the provider is requesting

If neither is included Medicare Plus Blue is not obligated to review the 2nd level appeal request. Medicare Plus Blue **will notify the provider of the decision within 45 calendar days** of receiving all necessary information. The plan's 2nd level appeal decision is final and there are no other appeal options available to the provider.

Contracted MI Provider acute inpatient admission appeals requested outside the filing timeframes

- 1st level request outside time frame -Medicare Plus Blue will deny the 1st level appeal request with a decision of untimely filing. Medicare Plus Blue will then process the appeal request as a 2nd level and the decision is final.
- 2nd level request outside of time frame – Medicare Plus Blue is not obligated to review the request.

Note: If an appeal request is received by BCBSM outside the designated time frame, BCBSM is not obligated to review the case.

BCN Advantage: Appeal process for inpatient acute care admissions

The process for submitting appeals of denied authorization requests for inpatient acute care admissions of BCN Advantage members is described in the Utilization Management chapter of the *BCN Provider Manual*.

Here's a snapshot from the section titled "Appealing utilization management decisions."

Appealing utilization management decisions

Filing deadlines for provider appeal requests

The table that follows outlines the filing deadlines for provider appeal requests.

Filing deadlines for provider appeal requests (medical necessity or medical appropriateness determinations)	
Expedited appeals	May be requested by a practitioner when circumstances require that a decision be made in a short period of time because a delay in making the decision may seriously jeopardize the life or health of the member. Retrospective appeals (when service has already been provided to the member) will not be considered for an expedited appeal. Requests for expedited appeals may be initiated verbally for decisions regarding precertification of urgent care and concurrent cases that result in denial. BCN notifies the provider of the decision within 72 hours of receiving the request. An expedited appeal can be initiated by calling a plan medical director or designee at 248-799-6312. This decision is final and no other appeal option is available to the provider.

Appealing utilization management decisions

Filing deadlines for provider appeal requests

The table that follows outlines the filing deadlines for provider appeal requests.

Filing deadlines for provider appeal requests (medical necessity or medical appropriateness determinations)	
Level One appeals	Must be submitted to BCN **within 45 calendar days of the date noted on the written denial notification**. Requests are to be in writing and must include additional clarifying clinical information to support the request. BCN notifies the provider of the decision within 30 calendar days of receiving all necessary information. Mail appeal requests to: Utilization Management — Provider Appeals, Mail Code C336 Blue Care Network P.O. Box 5043 Southfield, MI 48076-5043
Level Two appeals	Must be submitted to BCN **within 21 calendar days of the date noted on the Level One appeal decision notification**. Level Two appeal requests must be submitted in writing and must contain at least one of the following: • New or clarifying clinical information or • A clear statement that the provider is requesting a BCN physician reviewer different from the one who reviewed the Level One appeal If neither the clinical information nor the request for a different physician reviewer is included, BCN is not obligated to review the Level Two appeal request. All Level Two requests should be sent to the same address to which Level One appeal requests are sent. BCN notifies the provider of the decision within 45 calendar days of receiving all the necessary information. This decision is final.

Note: If an appeal request is received by BCN outside the designated time frame, BCN is not obligated to review the case. A letter is sent to the requesting provider either advising that the appeal was not reviewed or notifying the physician of the outcome of the request if the plan has chosen to review the case.