South Carolina

BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association

Medicare Advantage

Coverage Decisions/Organization Determinations

When you ask for a decision about a Medicare Advantage health benefit or the amount we will pay for a service, you are requesting a Coverage Decision, which is also called an Organization Determination. If your health care provider tells you that we will not cover a service, or if you are charged more than you think your copayment or coinsurance should be, you or your provider may ask us for an Organization Determination.

The following are examples of when you can ask us for an Organization Determination:

- You are requesting payment for a service furnished by a provider that you believe should have been reimbursed by the health plan
- You are requesting payment for out-of-the-area renal dialysis services
- You have been told we are reducing or discontinuing a previously authorized service
- You are requesting payment for emergency services

When you request an Organization Determination, you will receive a response from us within:

- 72 hours for a pre-service expedited decision
- 24 hours for a Part B drug expedited decision
- 14 days for a standard decision
- 72 hours for a Part B drug standard decision
- 60 days for payment

The process for requesting an Organization Determination is discussed in more detail in Chapter 9 of your ***Evidence of Coverage,*** *"What to do if you have a problem or complaint (coverage decisions, appeals, complaints)."* If you or your provider do not agree with the outcome of the initial Organization Determination, you or your provider may appeal the decision by requesting a Reconsideration. This is also called a Level 1 Appeal.

Appeals

You can file an appeal if you do not agree with our Organization Determination. You must make your appeal request within 60 calendar days from the date on the written notice we send to answer your request for an Organization Determination. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal.

You will receive a response from us on a Level 1 Appeal within:

- 72 hours for an expedited appeal
- 30 days for a pre-service standard appeal
- 7 days for a Part B standard appeal
- 60 days for payment

If our Plan says No to your Level 1 Appeal, we will forward the case file to the Independent Review Organization for a Level 2 Appeal. You will receive a response on a Level 2 Appeal from the Independent Review Organization within:

- 72 hours for an expedited appeal
- 30 days for a pre-service standard appeal
- 7 days for a Part B standard appeal
- 60 days for payment

If the Independent Review Organization says No to your appeal, you may be able to continue to a 3rd level appeal with an Administrative Law Judge (ALJ). The dollar value of the coverage you are requesting must meet a minimum amount. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final. The notice you get from the Independent Review Organization will tell you if the dollar value of the coverage you are requesting is high enough to continue with the appeals process.

If the ALJ denies your appeal, then your case may be reviewed by the Medicare Appeals Council (MAC). If your case is reviewed and denied by the MAC, then the notice you get will tell you whether the rules allow you to go on to the 5th and final level of appeal. If the rules allow you to go on, the written notice will tell you who to contact and what to do next if you choose to continue with your appeal. The 5th level appeal is reviewed by a judge at the Federal District Court. This is the last stage of the administrative appeals process.

You, your prescribing health care provider, or another person you name can file an appeal for you. The person you name would be your appointed representative. If you want some other person to act for you, you and that person must sign and date a statement that gives that person legal permission to act as your appointed representative.