STAR MEMBER COMPLAINTS INTRODUCTION

We will help members solve problems or complaints about their health care.

BCBSTX resolves complaints and appeals related to all service aspects of BCBSTX, including services provided by subcontractors.

Complaints include, but are not limited to:

- Access to health care services
- Care and treatment by a provider
- Issues having to do with how we conduct business

A BCBSTX member advocate is available to assist STAR members with their rights and responsibilities and the filing of complaints and appeals.

Complaints and appeals submitted to BCBSTX are tracked and trended, resolved within established time frames and referred to peer review when needed.

The member and his or her representative are given an opportunity to present evidence and any allegations of fact or law in person as well as in writing.
BCBSTX will inform the member of the time frame for providing necessary information, and make clear that limited time is available for expedited appeals.

Network physicians and other professional providers understand and agree that the Texas Health and Human Services Commission (HHSC) reserves the right and retains the authority to make reasonable inquiries and conduct investigations into provider and member complaints for STAR members.

BCBSTX and its providers are prohibited from discriminating and/or taking any punitive action against members or their representatives for making a complaint.

**STAR MEMBER COMPLAINTS**

A member, or his or her authorized representative, has the right to file an oral or written complaint at any time regarding any aspect of BCBSTX’s services if it is not related to an action. A complaint related to an action is considered an appeal, which is covered later in this chapter.

**HOW TO FILE A COMPLAINT**

Members may call Customer Service with a complaint or mail a complaint in writing.

**Submit a complaint by phone**

**Customer Service**

STAR 888-657-6061
TTY 711 (for members with hearing or speech loss)

**Submit a complaint by email**

GPDTXMedicaidAG@bcbsnm.com

**Submit a complaint by mail**

Blue Cross Blue Shield of Texas
Attn: Complaints and Appeals Department
P.O. Box 27838
Albuquerque, NM 87125-7838

**Acknowledgement of STAR Member Complaints**

STAR members will receive an acknowledgement letter from BCBSTX acknowledging their complaint. BCBSTX will send the letter within five business days of receipt of a member’s complaint.

**Resolution of STAR Member Complaints**

BCBSTX will investigate members’ complaints to develop a resolution. The investigation includes reviews by appropriate staff of the Complaints and Appeals Unit (C&A Unit) and, if necessary, the medical director.

BCBSTX may request medical records or an explanation from a provider about the issues raised in the complaint in order to help resolve a complaint. Providers may be notified by BCBSTX by phone, mail or fax. Written correspondence to providers will include a signed and dated letter. All providers are expected to comply with requests for additional information within 10 calendar days.
STAR Member Complaints about Clinical Quality Issues

Clinical quality issues are reviewed by the medical director, who assigns a severity level and makes recommendations. All practitioners are evaluated for a history of trends during the 36 months prior to the current complaint. High-risk and high-volume complaints are presented to the Clinical Quality Improvement Committee (CQIC). When warranted, the CQIC presents the case to the Credentials Committee (CC).

OTHER OPTIONS FOR FILING COMPLAINTS

How to File a Complaint with the Texas Health and Human Services Commission

If a member is still not satisfied after completing BCBSTX’s complaint procedures, the member may file a complaint directly with the Texas Health and Human Services Commission (HHSC).

Submit a complaint by phone
Toll-free: 877-787-8999
TTY (for hearing and speech impaired): 800-735-2989 or National Relay Service 711

Submit a complaint by email
GPDTXMedicaidAG@bcbsnm.com

Submit a complaint by mail
Texas Health and Human Services Commission
Office of the Ombudsman, MC H-700
P.O. Box 13247
Austin, TX 78711-3247

STAR MEMBER APPEALS

Actions
1. Denial or limited authorization of a requested service, including the type or level of service
2. Reduction, suspension, or termination of a previously authorized service
3. Denial, in whole or in part, of payment for a service
4. Failure to provide services in a timely manner, as defined by the State
5. Failure of BCBSTX to act within the timeframes provided in § 438.408(b); or
6. For a resident of a rural area with only one plan, the denial of a STAR member’s request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network.
Appeals

An appeal is a request by a member to have BCBSTX reconsiders an adverse determination. Two types of appeals are explained in detail in this chapter:

- **Standard Appeals** - A Standard Appeal is when a STAR member or his or her authorized representative requests that BCBSTX reconsider the denial of a service or payment for services, in whole or in part.

- **Expedited Appeals** – A member may request an Expedited Appeal when the amount of time necessary to participate in a standard appeal process could jeopardize the member’s life, health or ability to attain, maintain or regain maximum function.

**STAR Member Standard Appeals**

BCBSTX members have the right to appeal any services denied by BCBSTX because it was determined that they were not medically necessary. A denial of this type is called an ‘Action’.

A STAR member or his or her authorized representative may submit an oral or written appeal regarding an Action within 30 days from receipt of the denial letter.

With the exception of expedited appeals, all oral appeals must be confirmed in writing and signed by the member or his or her authorized representative.

The member and his or her authorized representative are given an opportunity, before and during the appeal process, to examine the Member’s case file, including medical records and any other documents considered during the appeal process. BCBSTX will inform the member of the time line available for providing additional information and that limited time is available for expedited appeals.

When the appeal is the result of a medical necessity determination, a Physician Clinical Reviewer (PCR) of the same or similar specialty and who was not involved in the initial decision reviews the case. The PCR contacts the provider, as necessary, to discuss possible alternatives.

Appeals should be submitted to BCBSTX at the following address:

**Blue Cross and Blue Shield of Texas**  
**Attn:** Complaints and Appeals  
PO Box 27838  
Albuquerque, NM 87125-7838
TIMELINE FOR STAR MEMBER APPEALS

Acknowledgement of STAR Member Appeals
STAR members will receive an Acknowledgement Letter from BCBSTX acknowledging their appeal. BCBSTX will send the letter within five business days of receipt of a member’s appeal.

Response to STAR Member Appeals
Once an oral or written appeal request is received, the case is investigated by the Complaints and Appeals Unit. The member, the member’s authorized representative and the physician or other professional provider are all given the opportunity to submit written comments, documentation, records and other information relevant to the appeal. BCBSTX may request medical records or a physician or other professional provider explanation of the issues raised in the appeal by telephone or with a signed and dated letter by mail or fax. Physicians and other professional providers are expected to comply with the request for additional information within 10 calendar days.

If the information requested from the provider is not submitted to BCBSTX within 16 business hours, we will send a letter to the member indicating the request cannot be acted upon until the documentation/information is provided. We will include a copy of the letter sent to the physician or other professional providers describing the documentation/information that needs to be submitted.

Resolution of Standard Appeals
Standard appeals are resolved within 30 calendar days of receipt of the initial written or oral request. Members are notified in writing of the appeal resolution, including their appeal rights within 30 calendar days from receipt of the appeal request.

Extensions
The resolution time frame for an appeal not related to an ongoing hospitalization or emergency may be extended up to 14 calendar days if:

- The member or his or her representative requests an extension
- BCBSTX shows that there is a need for additional information and how the delay is in the member’s interest

If the resolution time frame is extended for any reason other than by request of the member, BCBSTX will provide written notice of the reason for the delay to the member.

While an appeal of medical necessity of services is pending, the provider may ask the member to sign a financial responsibility form in order to continue services during the appeal period. The member and provider may also choose to discontinue services to await the final decision. If the final determination of the appeal is in the member’s favor, we will authorize coverage of and arrange for provision of the appealed services promptly and as expeditiously as the member’s health condition requires. If the final determination is in the member’s favor and the member received the appealed services, we will pay for those services.
STAR MEMBER EXPEDITED APPEALS

If the amount of time necessary to participate in a standard appeal process could jeopardize the member’s life, health or ability to attain, maintain or regain maximum function, the member may request an expedited appeal.

BCBSTX will inform the member of the time available for providing information, and that limited time is available for expedited appeals.

A STAR member may request an expedited appeal in the same manner as a standard appeal, but should include information informing BCBSTX of the need for the expedited appeal process.

Members may call Customer Service or write to BCBSTX to request an Expedited Appeal:

**Request an expedited appeal by phone**
Customer Service
STAR: **888-657-6061**
CHIP: **888-657-6061**; TTY **711**

**Request an expedited appeal by mail**
Blue Cross Blue Shield of Texas
Attn: Complaints and Appeals Department
P.O. Box 27838
Albuquerque, NM 87125-7838

**Timeline for STAR Members to Request an Expedited Appeal**
Members have the right to request an expedited appeal within 30 days of receipt of the denial letter.

**STAR – Acknowledgement of Expedited Appeals**
Expedited appeals are acknowledged by telephone, if possible, within one business day. BCBSTX will follow up with an acknowledgement in writing.

If BCBSTX denies a request for an expedited appeal, BCBSTX must:
- Transfer the appeal to the time frame for standard resolution.
- Make a reasonable effort to give the member prompt oral notice of the denial, and follow up within two calendar days with a written notice.

**Response to Expedited Appeals**
BCBSTX may request medical records or a physician or other professional provider explanation of the issues raised in the appeal by telephone or with a signed and dated letter by mail or fax. Physicians or other professional providers are expected to comply with the request for additional information within one business day.
Resolution of Expedited Appeals

BCBSTX resolves expedited appeals as quickly as possible and within three business days. The member is notified by telephone of the resolution, if possible, and a written resolution is sent. However, if the appeal is for an ongoing emergency or denial of continued hospitalization, the appeal will be completed according to the medical or dental immediacy of the case but not later than one business day after the request for the expedited appeal is received.

Specialty Provider Reviews

When an appeal is denied the provider can request for a Specialty Provider Review. The provider must make the request within 10 days and provide a good reason why the specialty review is needed. The denial will be reviewed by a health care provider who works in the same or similar specialty as the condition, procedure or treatment under discussion for review. This specialty review will be completed within 15 working days from receipt of the request.

Continuation of STAR Member Benefits during Appeal

To help ensure continuation of currently authorized services, members must file the appeal within 10 calendar days after BCBSTX mails a denial letter, or within 10 calendar days of the intended effective date of the proposed Action.

BCBSTX will continue the benefits currently being received by the member, including the benefit that is the subject of the appeal, if all of the following criteria are met:

- The appeal involves the termination, suspension or reduction of a previously authorized course of treatment
- The services were ordered by an authorized physician or other professional provider
- The period covered by the original authorization has not expired
- The member requests an extension of benefits
- If, at the member’s request, BCBSTX continues or reinstates the member’s benefits while the appeal is pending, the benefits must be continued until one of the following occurs:
  - The member withdraws the appeal.
  - 10 Calendar days pass after BCBSTX mails the notice resolving the appeal against the member, unless the member, within the 10-day time frame, has requested a Fair Hearing with continuation of benefits until the Fair Hearing decision can be reached.
  - A Fair Hearing officer issues a hearing decision adverse to the member, or the time period, or service limits of a previously authorized service have been met.

The member may be required to reimburse BCBSTX for the cost of services furnished while the appeal is pending, if the final decision is adverse to the member.

If BCBSTX reverses a decision to deny, limit or delay services that were not furnished while the appeal was pending, BCBSTX will authorize or provide the disputed services as promptly and expeditiously as the member’s health condition requires.

If such a decision was made by BCBSTX and the member received the disputed services while the appeal was pending, BCBSTX will be responsible for payment of the services.
STATE FAIR HEARING INFORMATION

Can a member ask for a State Fair Hearing?
If a member, as a member of the health plan, disagrees with the health plan’s decision, the member has the right to ask for a fair hearing. The member may name someone to represent him or her by writing a letter to the health plan telling BCBSTX the name of the person the member wants to represent him or her. A provider may be the member’s representative. The member or the member’s representative must ask for the fair hearing within 90 days of the date on the health plan’s letter that tells of the decision being challenged. If the member does not ask for the Fair Hearing within 90 days, the member may lose his or her right to the fair hearing. To ask for a fair hearing, the member or the member’s representative should either send a letter to the health plan at:

Blue Cross Blue Shield of Texas
Attn: Complaints and Appeals Department
P.O. Box 27838
Albuquerque, NM 87125-7838
Or, call Customer Service at 888-657-6061.

Timeline for STAR Members to Request a State Fair Hearing
If the member asks for a fair hearing within 10 days from the time the member gets the hearing notice from the health plan, the member has the right to keep getting any service the health plan denied, at least until the final hearing decision is made. If the member does not request a fair hearing within 10 days from the time the member gets the hearing notice, the service the health plan denied will be stopped.

Response to STAR Member Request for a State Fair Hearing
If the member asks for a fair hearing, the member will get a packet of information letting the member know the date, time and location of the hearing. Most fair hearings are held by telephone. At that time, the member or the member’s representative can tell why the member needs the service the health plan denied.

Resolution of STAR Member Request for a State Fair Hearing
HHSC will give the member a final decision within 90 days from the date the member asked for the hearing. If the hearing officer reverses a decision to deny, limit or delay services that were not furnished while the appeal was pending, BCBSTX will authorize or provide the disputed services promptly and as expeditiously as the member’s health condition requires.

If such a decision was made by the hearing officer and the member received the disputed services while the appeal was pending, BCBSTX will be responsible for payment of services.

BCBSTX members have the right to access the fair hearing process at any time during the appeal process. The only exception is when a member is requesting an expedited fair hearing. In the case of an expedited fair hearing, the member must first exhaust the BCBSTX expedited appeal process prior to requesting an expedited fair hearing.
CHIP MEMBER COMPLAINTS AND APPEALS INTRODUCTION

BCBSTX resolves complaints and appeals related to any aspect of service provided by BCBSTX or any subcontractor providing services on behalf of BCBSTX.

Complaints include, but are not limited to:

- Access to health care services
- Care and treatment by a provider
- Issues having to do with how we conduct business.

BCBSTX Customer Service can assist CHIP members with filing complaints and appeals.

Complaints submitted to BCBSTX are tracked and trended, resolved within established time frames and referred to peer review when needed.

The member and his or her representative are given an opportunity to present evidence and any allegations of fact or law in person as well as in writing.

BCBSTX will inform the member of the time available for providing the information, and that limited time is available for expedited appeals.

Network physicians and other professional providers understand and agree that the Texas Department of Insurance (TDI) reserves the right and retains the authority to make reasonable inquiries and conduct investigations into provider and member complaints for Medicaid (CHIP) members.

BCBSTX and its providers are prohibited from discriminating and/or taking any punitive action against a member or his or her representative for making a complaint.

Members who are not satisfied with BCBSTX's resolution of their complaint may file a complaint with the TDI. These procedures are outlined in this chapter.

Complaints

A member, or his or her authorized representative, has the right to file an oral or written complaint at any time regarding any aspect of BCBSTX's services that are not related to an Adverse Determination. A complaint related to an Adverse Determination is considered an appeal. Appeals are covered later in this chapter.

Adverse Determination

An Adverse Determination is defined as: a denial, modification, reduction or determination by BCBSTX or a PCP of a request for services based on eligibility, benefit coverage or medical necessity. Claims denials also are considered Adverse Determinations.
Appeals

An appeal is a request by a member to have BCBSTX reconsider an Adverse Determination. There are two types of Appeals that are explained in detail in this chapter:

- **Standard Appeals:** A Standard Appeal is when a CHIP member or his or her authorized representative requests that BCBSTX reconsider the denial of a service or payment for services, in whole or in part.

- **Expedited Appeals:** An Expedited Appeal is available when the amount of time necessary to participate in a standard appeal process could jeopardize the member’s life, health or ability to attain, maintain or regain maximum function.

CHIP MEMBER COMPLAINTS

HOW TO FILE A COMPLAINT

If a member has a problem or a complaint, the member, or someone they choose to act on their behalf, may call the Customer Service or mail the complaint in writing. A complaint may have to do with:

- Access to health care services
- Care and treatment by a provider
- Issues that have to do with how we conduct business

**Submit a complaint by phone**

Customer Service:
CHIP 888-657-6061
TTY 711 (for members with hearing or speech loss)

**Submit a complaint by mail**

Blue Cross and Blue Shield of Texas
Attn: Complaints and Appeals Department
PO Box 27838
Albuquerque, NM 87125-7838

**Submit a complaint by email**

GPDTXMedicaidAG@bcbsnm.com

Members can talk to their primary care provider (PCP) if they have questions or concerns about their care. If they still have questions or concerns, they should call BCBSTX Customer Service at the number above. Translators are available for those who do not speak English. Those with hearing or speech loss may call the TTY line above.

We will help members or the person they choose to act on their behalf to solve problems or complaints about their health care. Members will not be penalized for filing a complaint.
If a member wants to file a complaint for any reason, he or she should fill out a complaint form or write a letter to tell us about the problem. They can get complaint forms at the places where they get care, such as their PCP’s office. Here are the things they need to tell us as clearly as they can:

- Who is part of the complaint?
- What happened
- When did it happen
- Where did it happen
- Why they were not happy with their child’s health care services
- Attach any documents that will help us look into the problem

If the member cannot mail the form or letter, the member, or someone they choose to act on their behalf, can call our Customer Service and tell us about their problem.

Acknowledgement of CHIP Member Complaints

After we get the member’s complaint by phone or in the mail, we will send an acknowledgment letter within five business days.

Resolution of CHIP Member Complaints

BCBSTX will investigate members’ complaints to develop a resolution. The investigation includes reviews by appropriate staff of the Complaints and Appeals Unit and, if necessary, the medical director.

BCBSTX may request medical records or an explanation from a provider about the issues raised in the complaint in order to help resolve a complaint. Providers may be notified by BCBSTX by phone, mail or fax. Written correspondence to providers will include a signed and dated letter.

All providers are expected to comply with requests for additional information within 10 calendar days.

What are the requirements and time frames for filing a complaint?

The member will get a complaint resolution letter within 30 calendar days of the date we get their complaint. The letter will:

- Describe their complaint
- Tell what will be done to solve their problem
- Tell how to ask for a second review of their complaint with BCBSTX
- Tell how to ask for an internal appeal of our decision

CHIP MEMBER COMPLAINT APPEALS

When do members have the right to ask for a complaint appeal?

If a member would like to file a complaint appeal about how we solved the problem, the member must tell us within 30 calendar days after they get the complaint resolution letter. The complaint appeal must be filed in writing.
Complaint Appeals Not Involving Ongoing Emergencies or Continued Hospitalization

The Complaint Appeal Panel is composed of an equal number of BCBSTX staff members, physicians or other professional providers, and members. The physicians or other professional providers on the Complaint Appeal Panel must have experience in the area of care that is in dispute and must be independent of any provider who made any previous determination.

If specialty care is in dispute, the Complaint Appeal Panel must include a person who is a specialist in the field of care to which the appeal relates. BCBSTX members on the Complaint Appeal Panel may not be employees of BCBSTX.

No later than the fifth business day before the Complaint Appeal Panel is to meet, BCBSTX will provide the claimant or the claimant’s designated representative with any documentation to be presented to the Complaint Appeal Panel by BCBSTX, the specialization of any physicians or other professional providers consulted during the investigation and the name and affiliation of each BCBSTX representative on the Complaint Appeal Panel.

The complainant or complainant’s authorized representative is entitled to appear in person before the Complaint Appeal Panel, present alternative expert testimony and request the presence of and question any person responsible for making the disputed decision.

Complaints filed concerning dissatisfaction or disagreements with an Adverse Determination are addressed in the CHIP section of this manual on CHIP Member Appeals of Adverse Determinations.

Resolution of the Complaint Appeal

We will send the member a letter that tells them the final decision of the complaint appeal panel within 30 days of their request.

If a member is not happy with our decision, and the complaint appeal process is complete, they may file for a review by the Texas Department of Insurance. The member, or someone they choose to act on their behalf, may write to:

Texas Department of Insurance
HMO Quality Assurance Section
Mail Code 103-6A
P.O. Box 149104
Austin, TX 78714-9104

Complaint Appeals Involving Ongoing Emergencies or Continued Hospitalization

If the complaint appeal concerns an ongoing emergency or a denial of continued hospital stay that does not involve an Adverse Determination, BCBSTX will investigate and resolve the complaint in accordance with the medical immediacy of the case but no later than one business day after the receipt of the complaint.

At the member’s request and in lieu of an appeal panel, BCBSTX will have a physician or other professional provider who works in the same specialty review the issues raised in the appeal. This professional health care provider will be reviewing the case for the first time. The reviewing physician or provider may interview the member or the member’s authorized representative.
The reviewing physician or other professional provider will make a decision and give written notice of the decision to the member or the member’s authorized representative within three calendar days of the decision.

OTHER OPTIONS FOR FILING COMPLAINTS

CHIP Member Complaint to the Texas Department of Insurance

After exhausting BCBSTX’s complaint appeal process, if a CHIP member is still dissatisfied with the decision, the member may file a complaint with the Texas Department of Insurance at:

Texas Department of Insurance
HMO Quality Assurance Section
Mail Code 103-6A
P.O. Box 149104
Austin, TX 78714-9104

STANDARD APPEALS QUESTIONS AND ANSWERS

How will members find out if services are denied?

We may review some of the services the child’s doctor suggests. We may ask the doctor why the child needs some services. If we do not approve a service the child’s doctor suggests, we will send the member and the doctor a letter stating why it was denied.

What can members do if their doctor asks for a service for them that’s covered, but BCBSTX denies or limits it?

If we deny or limit a doctor’s request for service coverage, we will send the member a letter telling them how they can appeal our decision. The member or the child’s doctor can appeal a denial of medical service or payment for service. Call Customer Service line to learn more:

Customer Service 888-657-6061
TTY (for members with hearing or speech loss) 711

Do member requests have to be in writing?

We will take an oral or written request for an appeal. However, if the member files the appeal request orally, he or she must also send it to us in writing. With the exception of expedited appeals, all oral appeals must be confirmed in writing and signed by the member or his or her authorized representative.
Members have the right to have someone they trust act on their behalf and help them with their appeal request. Confidentiality is maintained throughout the process. The member, or someone they choose to act on their behalf, may ask for a complaint appeal in writing to:

Blue Cross and Blue Shield of Texas  
Attn: Complaints and Appeals Department  
P.O. Box 27838  
Albuquerque, NM 87125-7838

**What can a member do if they disagree with the appeal decision?**

When an appeal is denied the provider can request for a specialty provider review. The provider must make the request within 10 days and provide good reason why the specialty review is needed. The denial will be reviewed by a health care provider in the same or similar specialty as typically manages the medical or dental condition, procedure, or treatment under discussion for review. This specialty review will be completed within 15 working days from receipt of the request.

If the member still does not agree with the decision, the member or their doctor can ask for a review by an Independent Review Organization (IRO). The member may ask for an IRO review at any time during the appeal process. But they must go through our expedited (rush) appeal process before asking for an IRO review.

**What are the time frames for an appeal?**

Members must file a request for an appeal with BCBSTX within 30 days after getting the Notice of Action letter. We will send the member a letter within five business days to let them know that we received their appeal request.

The member may supply proof, or any claims of fact or law that supports the appeal, in person or in writing. We will let the member know when to do so. We will send a letter with the final decision of our internal review within 30 days of the request.

**EXPEDITED APPEALS QUESTIONS AND ANSWERS**

**What is an expedited appeal?**

An expedited (rush) appeal means we need to decide quickly because of the child’s health status. In other words, an expedited appeal is triggered if taking the time for a standard appeal may put the child’s life or health at risk.

**What happens if BCBSTX denies the request for an expedited appeal?**

If we deny a member’s request for a rush appeal, we must:

- Call the member to let them know that we denied their rush appeal.
- Follow up within two calendar days with a written notice.
- Let the member know what we decide within 30 days.
What can a member do if he/she disagrees with the appeal decision?

When an appeal is denied the provider can request a specialty provider review. The provider must make the request within 10 days and provide good reason why the specialty review is needed. The denial will be reviewed by a health care provider in the same or similar specialty as typically manages the medical or dental condition, procedure, or treatment under discussion for review. This specialty review will be completed within 15 working days from receipt of the request.

If the member still does not agree with the decision, the member or his or her doctor can ask for a review by an Independent Review Organization (IRO). The member may ask for an IRO review at any time during the appeal process. However, the member must complete our expedited (rush) appeal process before asking for an IRO review.

If the member has a life-threatening condition and services have not been received, the member does not have to request an appeal or reconsideration before requesting an independent review. This also applies if BCBSTX does not meet the time frames for processing the appeal.

What are the time frames for an expedited appeal?
We must decide no later than one working day after we get a member’s request.

How does a member ask for an expedited appeal?
A member or someone the member chooses to act on his or her behalf can ask for an expedited appeal orally or in writing. If the appeal request is filed over the phone, the member does not need to duplicate the request in writing.

Who can help members in filing an expedited appeal?
We can help Members or someone they choose to act on their behalf to file their appeals.

INDEPENDENT REVIEW ORGANIZATION QUESTIONS AND ANSWERS

What is an Independent Review Organization (IRO)?
An Independent Review Organization is the state system that may be used for a case’s final review. The IRO determines if members are getting the right health care services for medically necessary reasons. After members exhaust their right to appeal with us, they can ask for a review of the denial by using the IRO process. The member does not have to pay for an IRO review.

Members cannot always get an IRO review. It can be used only if we decide that the covered service or treatment is not medically necessary. It cannot be requested if the service they asked for is not covered in their contract.
How does a member ask for a review by an IRO?
Members may file for an IRO review by mailing the Texas Department of Insurance (TDI) IRO forms to:

Blue Cross Blue Shield of Texas  
Attn: Complaints and Appeals Department  
P.O. Box 27838  
Albuquerque, NM 87125-7838

This form will be attached to the appeal decision letter sent to the member. The form is also available on the Texas Department of Insurance website at [www.tdi.texas.gov/forms](http://www.tdi.texas.gov/forms).

How the Independent Review Organization (IRO) Process Works
We will send the member’s IRO request, the IRO form the member filled out, medical records and the information needed for an IRO review to the Texas Department of Insurance (TDI). The IRO must receive the information within three business days from the date of the review request.

The Texas Department of Insurance (TDI) will assign the member’s case to an Independent Review Organization (IRO) within one business day after it receives the member’s request. TDI will assign the member’s case between 7 a.m. and 6 p.m., Monday through Friday, except holidays. TDI will also inform all parties who is assigned to the member’s case.

What are the time frames for this process?
The normal time frame in which the IRO must reach a decision is:
- Within 15 days after getting the necessary information.
- No later than 20 days after the IRO gets its assignment.

When there is a condition that puts the member’s life at risk, the IRO must reach a decision:
- Within five days after it gets the information needed.
- No later than eight days after the IRO gets its assignment.

PHYSICIAN AND OTHER PROFESSIONAL PROVIDER COMPLAINTS
Physician and other professional provider complaints and appeals are classified into categories for processing by BCBSTX as follows:
- Complaints relating to the operations of BCBSTX
- Physician and other professional provider appeals related to Adverse Determinations
- Physician and other professional provider appeals of non-medical necessity claims determinations
Complaints Relating to the Operations of BCBSTX

Physicians and other professional providers may file written complaints involving:

- Dissatisfaction or concerns about another physician and other professional providers
- Operation of BCBSTX
- Members, if the complaints are not related to a claim determination or Adverse Determination

Complaints related to claim determination or Adverse Determination should be submitted in accordance with the procedures set forth later in this section.

Complaints submitted to BCBSTX are tracked and trended, resolved within established time frames and referred to peer review if needed.

BCBSTX may request medical records or an explanation of the issues raised in the complaint by telephone or a signed and dated letter by fax or mail. Providers are expected to comply with the request for additional information within 10 calendar days.

Providers are notified in writing of the resolution of the complaint including their appeal rights, if any. Findings or decisions of peer review or quality of care issues are not disclosed.

Network providers understand and agree that the Texas Department of Insurance (TDI) reserves the right and retains the authority to make reasonable inquiries and conduct investigations into provider and member complaints for CHIP members.

Physician and other professional provider complaints relating to operational issues may be submitted to the following address:

Blue Cross Blue Shield of Texas
Attn: Complaints and Appeals Department
P.O. Box 27838
Albuquerque, NM 87125-7838
Fax: 855-235-1055

The complaint must include the provider’s name, date of the incident, and a description of the incident.

Providers may also submit provider appeals through the Availity online tool at www.availity.com.

A Complaints and Appeals Representative receives and logs the physician and other professional provider’s complaint and sends an acknowledgement letter to the provider within five business days of receipt of the complaint. The Complaints and Appeals representative will investigate the provider complaint and respond to the provider in writing within 30 calendar days of receipt of the complaint.

STAR — Provider Appeals Related to Actions

A STAR member’s provider of record may submit an Adverse Determination appeal in accordance with the procedures set forth in STAR Member Appeals of Adverse Determinations. For post-service Adverse Determination appeals for which the provider is unable to obtain the member’s consent, a provider may use the Provider Claims and Appeal Process procedures outlined in the Claims and Billing Chapter.
CHIP — Provider Appeals Related to Adverse Determinations

A CHIP member’s physician and other professional providers of record may submit an Adverse Determination appeal in accordance with the procedures set forth in CHIP Member Appeals of Adverse Determinations. For post-service Adverse Determination appeals for which the physician or other professional provider is unable to obtain the member’s consent, a physician or other professional provider may use the Provider Claims and Appeal Process procedures set forth in the Claims and Billing chapter.

Provider Appeals of Non-Medical Necessity Claims Determinations

A physician or other professional provider may appeal a decision regarding payment for any service NOT related to Non-medical necessity determinations. For these appeals, the physician or other professional provider should follow the Provider Claims and Appeal Process procedures set forth in the Claims and Billing chapter.

Provider Complaint Process through the Texas Health and Human Services Commission (STAR)

If the Provider is dissatisfied with the resolution of the appeal for a STAR member service, and the provider has exhausted the BCBSTX complaints and appeals process, the provider has the right to complain through HHSC at:

Texas Health and Human Services Commission
Attn: Provider Complaints
Health Plan Operations, H-320
P.O. Box 85200
Austin, Texas 78708

Providers may also file a complaint or submit an inquiry via email to HPM_Complaints@hhsc.state.tx.us.

Provider Complaint and Appeal Process through the Texas Department of Insurance (CHIP)

If the provider is dissatisfied with the resolution of the appeal for a CHIP member service, and the provider has exhausted BCBSTX complaints and appeals process, the provider has the right to complain through TDI at:

Texas Department of Insurance
Consumer Protection (111-1A)
P.O. Box 149091
Austin, Texas 78714-9091

Phone: 512-463-6500 or 800-252-3439
Fax: 512-475-1771
Email ConsumerProtection@tdi.state.tx.us