Services Available to Members
Complaints & Appeals

Blue Cross and Blue Shield of Texas (BCBSTX) resolves complaints and appeals related to any aspect of service provided by itself or any subcontractor providing services on behalf of the plan.

STAR Member Introduction

The plan resolves complaints and appeals related to any aspect of service provided by itself or any subcontractor providing services on behalf of the plan.

Complaints include, but are not limited to:

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

A Member Advocate is available to assist Medicaid 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.

The Plan 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 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 Medicaid 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 the Plan’s resolution of their complaint may file a complaint with the Texas Health and Human Services Commission, the Texas Department of Insurance or request a State Fair Hearing. These procedures are outlined in this chapter.

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 the plan’s services that are not related to an action. A complaint related to an Action is considered an Appeal. Appeals are covered later in this chapter.

Actions

1. The denial or limited authorization of a requested service, including the type or level of service;
2. The reduction, suspension, or termination of a previously authorized service;
3. The denial, in whole or in part, of payment for a service;
4. The failure to provide services in a timely manner, as defined by the State;
5. The failure of the Plan 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.

Members cannot file a Complaint regarding an Action. A complaint regarding an Action is called an Appeal. Information about Appeals is contained later in this chapter.

**Appeals**

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

- **Standard Appeals** - A Standard Appeal is when a STAR member or his or her authorized representative request that the Plan reconsider the denial of a service or payment for services, in whole or in part.
- **Expedited Appeals** – An Expedited Appeal is 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, the member may request an expedited appeal.

**How to File a Complaint**

Members may call the Customer Care Center with a complaint or mail a complaint in writing.

**Submit a Complaint by Phone**

- **Customer Care Center**
  - **STAR** 888-292-4480
  - **TTY** 888-292-4485 (for members with hearing or speech loss)

**Submit a Complaint by Mail**

- **Attn:** Complaints and Appeals Unit
  - **Blue Cross and Blue Shield of Texas**
  - **P.O. Box 684249**
  - **Austin, TX 78768**

**Acknowledgement of STAR Member Complaints**

STAR members will receive a letter from the plan acknowledging their complaint. The plan will send the Acknowledgement Letter within five days of receipt of a member’s complaint.

Members who submit their complaint orally will be sent an Acknowledgement Letter and Complaint Form within five days of receipt of a member’s complaint. The member or his or her representative must complete the Complaint Form and return it to the plan.

**Resolution of STAR Member Complaints**

The Plan 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.

The Plan 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 the Plan 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 the Plan’s complaint procedures, the member may file a complaint directly with the Texas Health and Human Services Commission (HHSC).

Submit a Complaint by Phone          Submit a Complaint by Mail
Texas Medicaid Call                  Texas Health and Human Services Commission
Transfer Line                        Resolution Services- H-6100
800-252-8263- Select Option 5       1100 W. 49th Street
                                      Austin, TX 78756-3168

STAR Member Standard Appeals

BCBSTX members have the right to appeal any services that have been denied by the Plan because we 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. The Plan will inform the member of the time available for providing any 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 determination reviews the case. The PCR contacts the provider, as necessary, to discuss possible alternatives, as appropriate.

Timeline for STAR Members to File an Appeal

Appeals should be submitted to the Plan at the following address:

Attn: Complaints and Appeals Unit
Blue Cross and Blue Shield of Texas
PO Box 684249
Austin, TX 78768
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, the physician or other professional provider, or the physician or other professional provider on behalf of a member, is given the opportunity to submit written comments, documentations, records and other information relevant to the appeal. The Plan 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 fax or mail. Physician or other professional providers are expected to comply with the request for additional information within 10 calendar days.

Within 16 business hours, if the information requested by the provider is not submitted to the Plan, 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 for the appeal and a resolution letter describing the reason for the decision is sent to the member within that time frame.

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 or the Plan 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, the Plan will provide written notice of the reason for the delay to the member.

Members are notified in writing of the appeal resolution, including their appeal rights (if any), within 30 calendar days from receipt of the appeal request.

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.

STAR Member Expedited Appeals

The Plan will inform the member of the time available for providing the information, and that limited time is available for 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.

A STAR member may request an expedited appeal in the same manner as a standard appeal, but should include information informing the Plan of the need for the expedited appeal process.
Members may call the Customer Care Center or write to BCBSTX to request an Expedited Appeal:

<table>
<thead>
<tr>
<th>Request an Expedited Appeal by Phone</th>
<th>Request an Expedited Appeal by Mail</th>
</tr>
</thead>
<tbody>
<tr>
<td>Customer Care Center</td>
<td>Attn: Complaints and Appeals Unit</td>
</tr>
<tr>
<td>STAR 888-292-4480</td>
<td>Blue Cross and Blue Shield of Texas</td>
</tr>
<tr>
<td>CHIP 888-292-4480</td>
<td>P.O. Box 684249</td>
</tr>
<tr>
<td></td>
<td>Austin, TX 78768</td>
</tr>
</tbody>
</table>

**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 the Plan denies a request for an expedited appeal, the Plan 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**

The Plan 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 fax or mail. Physicians or other professional providers are expected to comply with the request for additional information within one business day.

**Resolution of Expedited Appeals**

The Plan resolves expedited appeals and quickly as possible, but not to exceed three 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.

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.

**Continuation of STAR Member Benefits During Appeal**

To help ensure continuation of currently authorized services members must file the appeal on or before the latter of 10 calendar days following the Plan’s mailing of a denial letter, or the intended effective date of the proposed Action.
The Plan 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, the Plan 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.
  - Ten calendar days pass after the Plan 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 the Plan for the cost of services furnished while the appeal is pending, if the final decision is adverse to the member.

If the Plan reverses a decision to deny, limit or delay services that were not furnished while the appeal was pending, the Plan 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 Plan and the member received the disputed services while the appeal was pending, the Plan will be responsible for the payment of the services.

**State Fair Hearing Procedures Applicable to STAR Members**

Note: The State Fair Hearing process does not apply to complaints by members, only to appeals of an Action.

 Expedited requests for State Fair Hearings generally occur when there is a life or death situation that must be immediately addressed and the member is not receiving adequate resolution from the plan to address the immediate needs. However, the member must first exhaust the Plan’s internal expedited appeal process prior to filing an expedited State Fair Hearing request.

The member does not have a right to a State Fair Hearing if Medicaid does not cover the service requested. The member also can ask the hearing officer to review the information sent in and make a decision.

If the member disagrees with the health plan’s decision, they have the right to ask for a fair hearing. The member may name someone to represent them by writing a letter to the health plan telling them the name of the person they want representing them. A provider may be the member’s representative.

The member or their representative must ask for the fair hearing within 90 days of the date on the health plan’s letter that tells of the decision they are challenging. If the member does not ask for the fair hearing within 90 days, they may lose their right to a fair hearing.
To ask for a fair hearing, the member or his or her representative should either send a letter to the health plan at:

**Request a State Fair Hearing by Phone**
888-292-4480

**Request a State Fair Hearing by Mail**
Blue Cross and Blue Shield of Texas
P.O. Box 684787
Austin, TX 78768

**Timeline for STAR Members to Request A State Fair Hearing**

If a member asks for a fair hearing within 10 days from the time they get the hearing notice from the health plan, they have 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 he or she gets the hearing notice, the service the health plan denied will be stopped.

**Response to STAR Member Request for A State Fair Hearing**

Members who request a State Fair Hearing will be sent information about the date, time and location of their hearing. At that time, the member or his or her representative can explain why he/she needs the service the Plan denied. HHSC will give the member a final decision within 90 days from the date they requested the hearing.

**Resolution of STAR Member Request for A State Fair Hearing**

The Texas Health and Human Services Commission will give the member a final decision within 90 calendar days from the date the hearing was requested. If the hearing officer reverses a decision to deny, limit or delay services that were not furnished while the appeal was pending, the Plan 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, the Plan will be responsible for the payment of the services.

**CHIP Member Introduction**

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

Complaints include, but are not limited to:

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

Customer Service can assist CHIP members with the filing of 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. The Plan 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 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 the Plan’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 the plan’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

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 the Plan 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 STAR member or his or her authorized representative request that the Plan reconsider the denial of a service or payment for services, in whole or in part.

- Expedited Appeals – An Expedited Appeal is 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, the member may request an expedited appeal.

CHIP Member Complaints

How to File A Compliant

What should a member do if he or she has a complaint? Who can they call?

If a member has a problem or a complaint, BCBSTX would like to hear from them. Members may call the Customer Care Center with a complaint or mail a 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 do our business.
Members can talk to their child's PCP if they have questions or concerns about their child's care. If they still have questions or concerns, the member should call us at our Customer Care Center at the number above. Members with hearing or speech loss may call the TTY line. We can get someone to translate for members who do not speak English.

We will help members solve any problems or complaints about their health care. No member will be treated in a different way 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 child's 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 Care Center 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 them an acknowledgment letter within five calendar days.

**Resolution of CHIP Member Complaints**

The Plan 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.

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

If the member is not satisfied with the outcome, what else can he or she do?

A member must file a complaint appeal with us in writing.

**CHIP Member Complaint Appeals**

**When do members have the right to ask for an appeal?**

If a member would like to file a complaint appeal about how we solved their problem, they must tell us within 30 calendar days after they get the complaint resolution letter.

**Complaint Appeals Not Involving Ongoing Emergencies or Continued Hospitalization**

The Complaint Appeal Panel is composed of an equal number of the Plan staff members, physicians or other 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. The Plan members on the complaint panel may not be employees of the Plan.

No later than the fifth business day before the Complaint Appeal Panel is to meet, the Plan will provide the claimant or the claimant’s designated representative with any documentation to be presented to the Complaint Appeal Panel by the Plan, 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 that resulted in the appeal.

Complaints filed concerning dissatisfaction or disagreement with an Adverse Determination are addressed in the CHIP section of this manual on [CHIP Member Appeals of Adverse Determinations](#).

**Do members have the right to meet with a complaint appeal panel?**

The member or the child has a right to appear in person before a complaint appeal panel. They also can mail a written complaint appeal to the complaint appeal panel. They can give us proof, or any claims of fact or law that supports their appeal, in person, or in writing. They also may show proof to the complaint appeal panel.

**How will members be told the outcome of the complaint appeal? What are the time frames for the complaint appeal decision?**
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 I a member is not pleased with the outcome, who else can they contact?**

If a member is not happy with our decision on their complaint appeal, they may file for a review by the Texas Department of Insurance. They only can file for a review after they go through our complaint appeal process. They may write to:

**Texas Department of Insurance**  
**HMO Quality Assurance Section**  
**Mail Code 103-6A**  
**PO 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, The Plan 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, the Plan shall provide review of the issues raised in the appeal by a physician or other professional provider of the same or similar specialty as a physician or other professional provider that would typically manage the member’s medical condition and that has not previously reviewed the case.

The reviewing physician or provider may interview the member or the member’s authorized representative.

The reviewing physician or other professional provider shall decide the appeal 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 the Plan’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**

**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 that says 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 coverage for service, we will send the member a letter to tell 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 our CCC line to learn more.

Customer Care Center (CCC) 888-292-4480
TTY (for members with hearing or speech loss) 888-292-4485

Do member requests have to be in writing?

We will take an oral or written request for an appeal. If the member files their appeal request orally, they also must send it to us in writing. Members have the right to have someone they trust act on their behalf and help them with their review request. 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. 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:

Attn: Complaints and Appeals Unit
Blue Cross and Blue Shield of Texas
PO Box 684249
Austin, TX 78768

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.

Timeline for CHIP Members to File an Appeal

What are the time frames for an appeal?

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

The member can give us proof, or any claims of fact or law that support their appeal, in person or in writing. We will let the member know when to do so. The member will get a letter that will tell them the final decision of our internal review within 30 days of their request.

Expedited Appeals

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, 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:

- Let the member know what we decide within 30 days.
- Call the member to let them know that we denied their rush appeal.
- Follow up within two calendar days with a written notice.

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 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 can ask orally or in writing. If the member files their rush appeal orally, they do not need to also send it to us in writing.

Who can help members in filing an expedited appeal?

We can help members file their appeals.

**Independent Review Organization**

What is an Independent Review Organization (IRO)?

An independent review is a system for a final review to decide if members can get the right health care services that they need for medical reasons (medically necessary). After members use up their appeal rights 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.

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 form to:

Attn: Complaints and Appeals Unit  
Blue Cross and Blue Shield of Texas  
PO Box 684249  
Austin, TX 78768

This form will be attached to the appeal decision letter sent to the member.
How the Independent Review Organization (IRO) Process Works

We will send the member’s IRO request, the IRO form that they filled out, medical records and the information needed for an IRO review to the Texas Department of Insurance (TDI).

The Texas Department of Insurance (TDI) will assign the member’s case to an Independent Review Organization (IRO) within one business day after it gets 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 also will tell all parties who is assigned to the member’s case.

The IRO must get the information within three business days from the date of the review request.

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 it gets the information needed.
- 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.

Members cannot always get an IRO review. It only can be used if we decide that the covered service or treatment is not medically necessary. Members cannot ask for an IRO review if the service they asked for is not covered in their contract.

Physician and Other Professional Provider Complaints

Physician and other professional provider complaints and appeals are classified into categories for processing by the Plan as follows:

- Complaints relating to the operations of the Plan,
- Physician and other professional provider appeals related to Adverse Determinations, and
- Physician and other professional provider appeals of nonmedical necessity claims determinations.

Complaints Relating to the Operations of the Plan

Physician and other professional provider providers may file written complaints involving dissatisfaction or concerns about another Physician and other professional provider, the operation of the Plan, or a member, that are not related to a claim determination or Adverse Determination. Complaints related to these issues should be submitted in accordance with the procedures set forth in this section.

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

The Plan 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:

Attn: Complaints and Appeals Unit
Blue Cross and Blue Shield of Texas
PO Box 684249
Austin, TX 78768

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

A C&A 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 C&A will investigate the provider complaint and respond to the provider in writing within 30 calendar days of receipt of the complaint.

STAR — Physician and Other Professional 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 set forth in the Claims and Billing Chapter.

CHIP — Physician and Other Professional Provider Appeals Related to Adverse Determinations

A CHIP member’s physician and other professional provider 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 the payment of a claim that is not related to a medical necessity determination. For these appeals, 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

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

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

Texas Department of Insurance
PO Box 149091
Austin, Texas 78714-9091
Phone: 512-463-6500 or 800-252-3439
Fax: 512-475-1771
e-Mail www.tdi.state.tx.us