PART 13

How to Resolve a Problem with BCBSTX

Complaints

What should I do if I have a complaint? Who do I call?

We care about the quality of service you get from BCBSTX and the health care providers in your network. If you are unhappy with BCBSTX or Medicaid services, you, or someone acting on your behalf, can file a complaint over the phone by calling the BCBSTX Customer Advocate Department toll-free at **1-888-657-6061** (TTY **711**). We also have a bilingual Member Advocate who can help you file your complaint. You can reach the Member Advocate at **1-877-375-9097**. If you do not speak English we will get a translator to help you file your complaint. Most of the time, we can help you right away or at the most within a few days.

You can file a complaint in writing with BCBSTX by downloading the Complaint Form located on the Forms and Documents page at www.bcbstx.com/star or call the Customer Advocate Department to have one mailed to you. Send the completed form to:

Blue Cross and Blue Shield of Texas
Attn: Complaints and Appeals Department
P.O. Box 660717
Dallas, Texas 75266-0717
Fax: **1-855-235-1055**

GPDTXMedicaidAG@bcbsnm.com.

How do I file a complaint with HHSC after I have gone through the BCBSTX process?

Once you have gone through the BCBSTX complaint process, you can complain to the Health and Human Services Commission (HHSC) by calling toll-free **1-866-566-8989**. If you would like to make your Complaint in writing, please send it to the following address:

Texas Health and Human Services Commission
Ombudsman Managed Care Assistance Team
P.O. Box 13247
Austin, Texas 78711-3247

If you can get on the Internet, you can submit your complaint at: www.hhs.texas.gov/managed-care-help

If you do not have access to the internet, you can call Member Outreach at **1-877-375-9097** (TTY: **711**) if your complaint has to do with:

- Access to health care services.
- Provider care and treatment.
- Administrative issues

Can someone from BCBSTX help me file a complaint?

A BCBSTX Member Advocate can help you file a complaint. You can reach a Member Advocate at **1-877-375-9097**. You should also talk to your PCP if you have questions or concerns about your care. No member will be treated differently for filing a complaint.

If you want to file a complaint for any reason, complete a complaint form, or tell us about the problem in a letter. Clearly tell us who is involved in the complaint, what happened, when and where it happened, and why you are not happy with your health care services.

Attach any documents that will help us look into the problem. You can find complaint forms on our website, www.bcbstx.com/star.

You or someone acting on your behalf can also call the Customer Advocate Department to ask for a complaint form or for help filing your complaint.

Send your completed complaint form or letter by mail or fax to:

Blue Cross and Blue Shield of Texas
Attn: Complaints and Appeals Department
P.O. Box 660717
Dallas, Texas 75266-0717
Fax: **1-855-235-1055**

How long will it take to process my complaint? What are the requirements and timeframes for filing a complaint?

We will send you an acknowledgement letter within five business days after we get your complaint.

We will send you a complaint resolution letter within 30 calendar days after we get your complaint. The letter will:

- Describe your complaint
- Tell you what will be done to solve your problem
- Tell you how to ask for a second review of your complaint with BCBSTX
- Tell you how to ask for an internal appeal of our decision.
- Tell you how you can contact HHSC if you are not satisfied with the outcome of your complaint after you finish the entire BCBSTX complaints process

Appeals

What can I do if my doctor asks for a service or medicine for me that is covered but the health plan denies it or limits it?

If we do not approve coverage for a service or medicine your doctor suggests, we will send your doctor a letter to explain the reason for our denial. You will also get a letter that explains the reason for our denial. This is called a Notice of Action letter. It will tell you how to appeal.

When does a member have the right to ask for an appeal?

If you are not happy with a decision BCBSTX made about your care, you can file a health plan appeal. When you file an appeal, BCBSTX will take another look at your case to see if there is something else we can do to solve your problem. You may use the Health Plan Appeal Request Form or call our Customer Advocate Department at **1-888-657-6061** (TTY **711**).

Your doctor can also appeal a denial of coverage for a medical service or payment for service, in whole or in part. You must file a request for an appeal with us within 60 days after you get the Notice of Action letter.

You may be able to keep getting your services during the health plan appeal process. You can ask for this by checking "Yes" where it says, "Do you want your services to continue?" on the Health Plan Appeal Request Form. You can also call BCBSTX at **1-888-657-6061** and say you want to keep your services during your appeal if the appeal is about a course of treatment that:

- Has ended
- Has been stopped for a while
- Has been reduced
- If the services were ordered by an approved doctor

- If the first amount of time covered by the approval has not ended
- You ask for the benefits to last longer

You, or your doctor acting on your behalf, must ask for the appeal within 10 calendar days from the date on the notice of action stating that the service you asked for was not approved. If you lose your health plan appeal, you may have to pay BCBSTX back for services provided to you during your appeal. BCBSTX cannot ask you to pay us back for services you received without first asking permission from HHSC.

Can someone from BCBSTX help me file an appeal? Does my request have to be in writing?

You, or someone you choose to represent you, may ask for an appeal in writing or by calling the Customer Advocate Department. You may ask for an appeal for reasons such as:

- A denial of a claim in whole or in part
- A limited authorization
- The type or level of service and the denial

A BCBSTX Member Advocate can help you file an appeal. Every oral internal BCBSTX appeal must be confirmed by a written appeal signed by you, or your Legally Authorized Representative (LAR), unless it is an expedited (rush) appeal.

What if BCBSTX needs more information to make a decision on my appeal? What if I want to give more information about my case to BCBSTX to support my appeal?

BCBSTX might need 14 more days to decide on your appeal if we believe that the extra time will help us make a better decision on your standard or expedited appeal.

Members or Legally Authorized Representatives (LARs) can ask for 14 extra days if they feel like more time is needed to get BCBSTX information that can help us make a decision.

If the timeframe is extended, and you did not ask for the delay, we will give you written notice of the reason for the delay. You can give us proof, or any claims of fact or law that support your appeal, in person or in writing.

How will I find out if services are denied after I request an appeal?

You will be mailed a Notice of Action letter that will tell you if your services have been denied or reduced.

Emergency Health Plan Appeal

What is an emergency BCBSTX appeal?

An emergency appeal is when the health plan has to make a decision quickly based on the condition of your health and taking the time for a standard appeal could jeopardize your life or health.

How do I ask for a BCBSTX emergency appeal?

You have the right to give written comments, documents, or other information, for your appeal either by calling or in writing.

Who can help me file an Emergency Health Plan appeal with BCBSTX?

Call the Customer Advocate Department or a Member Advocate if you need help filing an emergency health plan appeal. If we deny a request for an emergency appeal, we must:

- Transfer the appeal to the standard timeframe to resolve it
- Make a reasonable effort to give you quick oral notice of the denial
- Follow up within two calendar days with a written notice

What is the timeframe for an emergency BCBSTX appeals process?

If your request for an emergency appeal is approved, we give you our decision within 72 hours. We will call you to tell you our decision and we will also send a letter. If your request for a faster appeal is about an emergency that keeps occurring or denial of a hospital stay while you are still in the hospital, we will look at your case and tell you our decision within one (1) working day.

If we do not approve the emergency appeal after we look at your case, then your appeal will go through the standard appeal steps. We will call you and send a letter to let you know what has been decided within two (2) calendar days.

How will I find out if services are denied after I request an emergency BCBSTX appeal?

For an emergency appeal, we will call you within 72 hours after we get your request. You will also get a letter with our decision.

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

If we do not approve the emergency appeal after we look at your case, then your appeal will go through the standard appeal steps.

State Fair Hearing

Can I ask for a State Fair Hearing?

If you, as a member of the health plan, disagree with the health plan's internal appeal decision, you have the right to ask for a State Fair Hearing. You may name someone to represent you by writing a letter to the health plan telling them the name of the person you want to represent you. A provider may be your representative. If you want to challenge a decision made by your health plan, you or your representative must ask for the State Fair Hearing within 120 days of the date on the health plan's letter with the internal appeal decision. If you do not ask for the State Fair Hearing within 120 days, you may lose your right to a State Fair Hearing. To ask for a State Fair Hearing, you or your representative should either send a letter to the health plan at:

Blue Cross and Blue Shield of Texas
Attn: Complaints and Appeals Department
P.O. Box 660717
Dallas, Texas 75266-0717
or call BCBSTX at **1-888-657-6061** (TTY **711**).

You have the right to keep getting any service the health plan denied or reduced, based on previously authorized services, at least until the final State Fair Hearing decision is made if you ask for a State Fair Hearing by the later of:

(1) 10 calendar days following the date the health plan mailed the internal appeal decision letter, or

(2) the day the health plan's internal appeal decision letter says your service will be reduced or end. If you do not request a State Fair Hearing by this date, the service the health plan denied will be stopped. If you ask for a State Fair Hearing, you will get a packet of information letting you know the date, time and location of the hearing. Most State Fair Hearings are held by telephone. At that time, you or your representative can tell why you need the service the health plan denied.

HHSC will give you a final decision within 90 days from the date you asked for the hearing.

Can I ask for an emergency External Medical Review?

If you believe that waiting for a standard External Medical Review will seriously jeopardize your life or health, or your ability to attain, maintain, or regain maximum function,

you, your parent or your legally authorized representative may ask for an emergency External Medical Review and emergency State Fair Hearing by writing or calling BCBSTX.

To qualify for an emergency External Medical Review and emergency State Fair Hearing review through HHSC, you must first complete BCBSTX's internal appeals process.

Can I ask for an emergency State Fair Hearing?

If you believe that waiting for a State Fair Hearing will seriously jeopardize your life or health, or your ability to attain, maintain, or regain maximum function, you or your representative may ask for an emergency State Fair Hearing by writing or calling BCBSTX. To qualify for an emergency State Fair Hearing through HHSC, you must first complete BCBSTX's internal appeals process.

External Medical Review Information

Can a member ask for an External Medical Review?

If a member, as a member of the BCBSTX, disagrees with BCBSTX's internal appeal decision, the member has the right to ask for an External Medical Review. An External Medical Review is an optional, extra step the member can take to get the case reviewed before the State Fair Hearing occurs.

The member may name someone to represent them by contacting the health plan and giving 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 External Medical Review within 120 days of the date the health plan mails the letter with the internal appeal decision.

If the member does not ask for the External Medical Review within 120 days, the member may lose his or her right to an External Medical Review. To ask for an External Medical Review, the member or the member's representative may either:

- Fill out the 'State Fair Hearing and External Medical Review Request Form' provided as an attachment to the Member Notice of the BCBSTX Internal Appeal Decision letter and mail or fax it to BCBSTX by using the address, or
- Fax number at the top of the form;
- Call BCBSTX at **1-888-657-6061** (TTY: **711**) or,
- Email BCBSTX at GPDTXMedicaidAG@bcbsnm.com.

If the member asks for an External Medical Review within 10 days from the time the member gets the appeal decision from the health plan, the member has the right to keep getting any service the health plan denied, based on previously authorized services, at least until the final State Fair Hearing decision is made.

If the member does not request an External Medical Review within 10 days from the time the member gets the appeal decision from the health plan, the service the health plan denied will be stopped.

The member may withdraw the member's request for an External Medical Review before it is assigned to an Independent Review Organization or while the Independent Review Organization is reviewing the member's External Medical Review request.

An Independent Review Organization is a third-party organization contracted by HHSC that conducts an External Medical Review during member appeal processes related to Adverse Benefit Determinations based on functional necessity or medical necessity. An

External Medical Review cannot be withdrawn if an Independent Review Organization has already completed the review and made a decision.

Once the External Medical Review decision is received, the member has the right to withdraw the State Fair Hearing request. If the member continues with the State Fair Hearing, the member can also request the Independent Review Organization be present at the State Fair Hearing. The member can make both of these requests by contacting the BCBSTX at **1-888-657-6061** (TTY **711**) or the HHSC Intake Team at EMR_Intake_Team@hhsc.state.tx.us.

If the member continues with a State Fair Hearing and the State Fair Hearing decision is different from the Independent Review Organization decision, it is the State Fair Hearing decision that is final. The State Fair Hearing decision can only uphold or increase member benefits from the Independent Review Organization decision.

Can I ask for an emergency External Medical Review?

If you believe that waiting for a standard External Medical Review will seriously jeopardize your life or health, or your ability to attain, maintain, or regain maximum function, you, your parent or your legally authorized representative may ask for an emergency External Medical Review and emergency State Fair Hearing by writing or calling BCBSTX.

To qualify for an emergency External Medical Review and emergency State Fair Hearing review through HHSC, you must first complete BCBSTX's internal appeals process.

PART 14

State Medicaid Resources

If We Can No Longer Serve You

We may not cover you if you:

- Move out of the BCBSTX service area permanently
- No longer have Medicaid

Your BCBSTX coverage is effective as of the date shown on the front of your BCBSTX ID card. It ends on the date given to BCBSTX by the HHSC. HHSC decides:

- The eligibility and enrollment for health plan members
- If a member is kept out of, or disenrolled from, the plan

To learn more, please call the HHSC Medicaid Hotline at **2-1-1** or **1-866-566-8989**.

Can BCBSTX ask that I get dropped from their plan for noncompliance?

BCBSTX may ask to disenroll you from our health plan if you:

- Let someone else use your BCBSTX ID card
- Are verbally abusive to your PCP, the office staff or other members
- Disrupt BCBSTX operations
- Make it a habit to use the ER for routine care
- Commit fraud
- Misrepresent yourself