

## **Blue Cross Blue Shield of Georgia (BCBSGa) Medical Necessity External Review Process**

Since January 4, 2007, the Medical Necessity External Review Process has been available to physicians who are class members of the Shane-Thomas Managed Care Settlement Agreement (“the Settlement Agreement”) and physician groups comprised of such physicians. The process is intended to resolve disputes regarding any determination made by BCBSGa that certain services are not covered services because they are not Medically Necessary or are experimental or investigational in nature (“**Adverse Determination**”). The process described herein only applies to the extent BCBSGa both makes the Adverse Determination and administers the Member appeals and/or external review processes

### **Pre-Service Appeals.**

Physicians shall have the right to file an appeal of an Adverse Determination made prior to rendering a proposed service (“**Pre-Service Appeals**”), if they are appealing on the Member’s behalf. For urgent Pre-Service Appeals, the physician shall be automatically deemed the authorized representative of the Member. For all other Pre-Service Appeals, authorization must be obtained from the Member in writing. Pre-Service Appeals filed by physicians on behalf of a Member will be handled by BCBSGa under the appeal process available to the Member based on the terms of the Member’s health benefit plan and the applicable state and federal laws and regulations. For information about the specific appeals process available to a specific Member, please contact BCBSGa by mail at PO Box 9907, Columbus, GA 31908 or by telephone at 800-441-2273.

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## **Post-Service Appeals**

Physicians shall have the right to file an appeal of an Adverse Determination made after a service has been rendered (“**Post-Service Appeals**”).

A physician who wishes to bring a Post-Service Appeal shall use best efforts to first seek written authorization to proceed as the Member’s representative. If the physician obtains the Member’s consent to proceed on the Member’s behalf, then the physician’s appeal rights are those of the Member’s and the physician will be bound by the decision rendered in the Member’s appeal process. In such situations, the Post-Service Appeal will be handled by BCBSGa under the appeal process available to the Member based on the terms of the Member’s health benefit plan and any applicable state and federal laws and regulations. For information about the specific appeals process available to a specific Member, please contact BCBSGa by mail at PO Box 9907, Columbus, GA 31908 or by telephone at 800-441-2273.

If, after using best efforts, a physician is unable to obtain written authorization to proceed as the Member’s representative with respect to a Post-Service Appeal, the physician may file an internal Post-Service Appeal by sending a writing request for review along with all relevant information to BCBSGa at PO Box 9907, Columbus, GA 31908. A nurse or other health care professional employed by BCBSGA may review the internal Post-Service Appeal and may grant but not deny the appeal. If the nurse or other healthcare professional does not grant the appeal, then a physician in the same specialty as the physician who treated the condition (“**Qualified Reviewer**”), designated by Company, other than the one that made the initial Adverse Determination, shall review and decide the internal appeal in accordance with applicable Company health care clinical guidelines. For purposes of this section, “same specialty” shall mean a physician with similar credentials and licensure as those who typically treat the condition or health problem in question in the appeal or a physician who has experience treating the same problems as those

in question in the appeal, in addition to experience treating similar complications of those problems.

All internal Post–Service Appeals filed by physicians shall be adjudicated within the time limits established under regulations issued by the Department of Labor regardless of whether ERISA applies.

### **Adverse Determination External Review Process for Physicians**

If the Company upholds an initial Adverse Determination through the internal Post–Service Appeals process and the cost of the service at issue exceeds the threshold amount, if any, the Member would need to satisfy in order to seek external review under the terms of the applicable health benefit plan, BCBSGa shall make available to the physician the option to seek external review of the Adverse Determination through an independent review organization (“**Independent Review Organization**”) identified by BCBSGa (“**External Review**”). A physician who wishes to receive External Review must, within sixty (60) days from the date of the internal Post–Service Appeal denial decision issued by BCBSGa, submit a written request for External Review to BCBSGa at PO Box 9907, Columbus, GA 31908 along with a filing fee of \$50; provided that if the matter involves services or supplies for which BCBSGa requires pre–certification then the filing fee shall be the lesser of (i) \$250 and (ii) the sum of \$50 and the amount by which the amount in dispute exceeds \$1,000. The physician shall be entitled to a refund of such filing fee in the event that the physician prevails in the External Review process.

A physician is not required to seek External Review and may instead choose any other remedy available as a matter of law or contract.

External Review is not available for a physician before the physician has exhausted the internal Post–Service Appeal process unless BCBSGa and the physician both agree to forego the internal Post–Service Appeal and proceed directly to External Review or BCBSGa cannot provide a Qualified Reviewer for internal appeal.

Any decision issued pursuant to an External Review process, regardless of whether such External Review process is initiated and pursued by a Member or a physician, shall be binding upon both the physician and BCBSGa.

BCBSGa will contract with the Independent Review Organization to conduct a de novo review of the case. For coverage issues other than a determination of Medical Necessity, the Member's health benefit Plan Documents will control. In the event an External Review process is initiated, BCBSGa shall promptly, but in any event no later than ten (10) business days following receipt of the request, submit documentation pertaining to the appeal to an Independent Review Organization. BCBSGa shall require that the Independent Review Organization provide a decision within thirty (30) days of BCBSGa's submission of all necessary information. The external reviewer designated to conduct the review by the Independent Review Organization shall be of the same specialty (but not necessarily the same sub-specialty) as the appealing Physician.

In the case of a state-required external review process that is available to physicians without the Member's consent and that is different than the process herein set forth, only the state-required program shall be utilized where applicable, consistent with § 7.11(b)(iii).

Notwithstanding the above and in addition to any requirements contained above, physicians may not initiate an internal Post-Service Appeal or External Review of any denied service if:

- (A) The Member (or his or her representative) or the physician (either independently where BCBSGa is required to accept an independent physician appeal by state law or as the Member's representative) filed a Pre-Service Appeal pertaining to the same denied service; or
- (B) The Member (or his or her representative) is currently seeking or has sought review related to the same denied service. In the event

that both the Member (or his or her representative) and a physician seek review of the same denied service, the Member's review shall go forward and the physician's request for review will be dismissed; or

- (C) As to External Review only, the Member is covered under a Self-Insured Plan and the Plan sponsor has not agreed by contract to participate in BCBSGa's External Review program; or
- (D) The Member (or his or her representative) has filed suit under § 502(a) of ERISA or other suit for the denial of health care services or supplies regarding an Adverse Determination. In that event, or if such a suit is subsequently initiated, the Member's lawsuit shall go forward and the physician's claims shall be dismissed and may not be brought by or on behalf of the physician in any forum; provided that such dismissal shall be without prejudice to any physician seeking to establish that the rights sought to be vindicated in such lawsuit belong to such physician and not to such Member.

Nothing contained herein is intended, or shall be construed, to supersede, alter or limit the rights or remedies otherwise available to any person under § 502(a) of ERISA or to supersede in any respect the claims procedures under § 503 of ERISA.

The determination made with respect to any Adverse Determination pursuant to any internal appeal and External Review process referenced herein shall not act as precedent as to any other Medical Necessity or experimental or investigational determination.