

Provider Bulletin August 2022

Important information about your appeal rights as a provider

As a provider, you have the right to appeal. If you are dissatisfied with a decision, you can file an appeal through the Anthem Blue Cross and Blue Shield Healthcare Solutions (Anthem) internal appeal process. You have **60 calendar days** from receipt of the initial denial. If you are dissatisfied with the way that Anthem paid your claim, you may appeal our decision within 60 calendar days of receipt of the *Explanation of Payment*. Mail your appeal to the address below:

Anthem Blue Cross and Blue Shield Healthcare Solutions Payment Dispute Unit P.O. Box 61599 Virginia Beach, VA 23466-1599

There are two levels of review for this type of dispute.

Filing a medical necessity or administrative appeal

If you have received a denial letter from Anthem and would like to file an appeal, you can call us at **844-396-2330** or submit a *Request for Appeal* form. You should mail your request to the address below:

Anthem Blue Cross and Blue Shield Healthcare Solutions Appeals Department P.O. Box 62429 Virginia Beach, VA 23466-2429

Appealing a medical necessity decision

A medical necessity appeal involves an Anthem decision where a service does not meet the health plan medical necessity criteria. The appeal will be reviewed by a physician with the same or similar credentials as the appealing physician who would usually treat the condition. The physician reviewing the appeal has no involvement in the initial denial and does not work for the initial reviewer. If you are appealing a medical necessity decision on behalf of a member, you must first obtain the member's written permission, unless you are requesting an expedited appeal. **There is only one level of review for provider medical necessity appeals.**

Appealing an administrative decision

An administrative appeal involves an Anthem determination based on noncompliance with a contractual arrangement. This decision was not based on medical necessity. Administrative appeals are reviewed by an Anthem associate who was not involved in the initial decision. **There is only one level of review for this type of appeal.**

What should I include with my appeal?

Your appeal request should include the member's name and ID number, date of service, description of services, and an explanation of why you believe the decision should be reversed. If you are appealing inpatient days, please include the appropriate medical records with your request in order to prevent a delay in processing your appeal.

https://providers.anthem.com/nv

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When will I receive a decision about my medical necessity or administrative appeal?

Standard appeal: We will notify you of our decision within 30 calendar days of receipt of your appeal. **Expedited appeal**: If your requested service involves an emergent or life-threatening situation, you can request an expedited appeal. A decision will be made no later than **72 hours** after we receive your appeal request. If you submit an urgent request that does not qualify, the Appeals department will contact you to notify you that the request will be processed in the standard appeal time frame.

What if I don't agree with your appeal decision?

If you do not agree with the decision made by Anthem in regard to a service that has already been performed, you may ask for a state fair hearing. Information regarding a hearing will be included with your decision letter, if applicable.

For a complete statement of appeal rights, please reference your Anthem provider manual or your provider agreement. If you need additional help, call us toll free at **844-396-2330** or call your Provider Relations representative at **702-228-1308**.



Email is the quickest and most direct way to receive important information from Anthem Blue Cross and Blue Shield Healthcare Solutions.

To start receiving email from us (including some sent in lieu of fax or mail), submit your information using the QR code to the right or via our online form (https://bit.ly/3lGTrCq).



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