

ERS' PARTICIPANT GUIDE TO THE APPEAL PROCESS

Employees Retirement System of Texas
Texas Employees Group Benefits Program

October 2018



Employees Retirement System of Texas

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EXECUTIVE SUMMARY

The Employees Retirement System of Texas (ERS) has administered insurance benefits for employees and retirees of State of Texas agencies since 1976. Beginning September 1, 1992, employees of certain institutions of higher education were added to program coverage. The ERS Board of Trustees designs and awards contracts for the various coverage and benefit options offered under the Texas Employees Group Benefits Program (GBP). The coverages and benefits provided by ERS are highly valued by employees of participating state agencies and institutions.

Each year, millions of claims are paid under the various GBP benefit plans, and only a small percentage of claims are submitted to the formal appeal process. While the health plans provide expansive health coverage, insurance plans can't cover everything. We want to be sure that you understand the process to appeal if you disagree with the decision to deny a claim.

0.008%

of the 6.1 million HealthSelect claims submitted, or 460 claims, were submitted for a second-level appeal to ERS in Plan Year 2017.

APPEAL GUIDE OVERVIEW

As part of ERS' ongoing commitment to participant education, we have created **ERS' Participant Guide to the Appeal Process**¹ (Appeal Guide). The Appeal Guide is designed to:



Provide an **Overview of the Appeal Process for the HealthSelectSM and Consumer Directed HealthSelectSM plans** in easy-to-understand terms. The Appeal Guide is designed to help you be better equipped to navigate the appeal process.



Provide a **Summary of Appeal Determinations** (Summary of Determinations) made by ERS related to common types of participant appeals using examples of sample decisions.

The examples provided in the Summary of Determinations section are a resource to help you understand decisions made about appeals and their potential impact on participants just like you.

The Summary of Determinations also provides insight on previous appeals with similar facts.

¹ The Appeal Guide is designed to serve and meet the statutory purpose and requirements set forth in §1551.363 of the Texas Insurance Code. The first publication of the Appeal Guide is specific to HealthSelect plans, including HealthSelectSM of Texas and Consumer Directed HealthSelectSM; future publications of the Appeal Guide will address the appeal process for other plans under the Texas Employees Group Benefits Program.

APPEAL GUIDE OVERVIEW

The Summary of Determinations does not create precedent or bind the ERS Board of Trustees and staff involved in the claims appeal process.²

This Appeal Guide provides an overview of the appeal process and illustrative determinations from previous appeals. The facts and circumstances of every appeal are unique and could lead to a determination that differs from the illustrations for various reasons.

² In accordance with §1551.363(c), the ERS Board of Trustees and staff involved in the claims appeal process are not bound by claims determinations presented in the Appeal Guide.

APPEAL GUIDE OVERVIEW

This publication of the Appeal Guide is:

- specific to the appeals for medical services under the HealthSelect of Texas and Consumer Directed HealthSelect plans; and
- designed to help you understand your role in the appeal process and the important deadlines involved.



HELPFUL IDEA

Have the ERS-administered benefit program's Master Benefit Plan Document available as you review the information included in this Appeal Guide³.

Open the Master Benefit Plan Document to the Claims Denials and Appeals section. This information will help you better understand the appeal process for each specific plan.

For more information about the Master Benefit Plan Document, see page 11 of the Appeal Guide.

³ In the event of a discrepancy or any conflict between the information provided in this APPEAL GUIDE and the applicable plan's Master Benefit Plan Document (MBPD), the terms of the applicable MBPD govern and take precedence over the information provided in this APPEAL GUIDE.

HOW TO USE THE APPEAL GUIDE

Don't have a denied claim? Let's keep it that way!

The Appeal Guide is designed as a tool to help you become familiar with the situations that could result in either a claim denial or a situation in which you could shoulder more of the cost than you expected.

We want you to understand your benefits and become familiar with steps you can take to keep this from happening to you.



In the middle of an appeal and feeling a bit confused by the process? Let's fix that!

The Appeal Guide will help you know what to expect and how to navigate through the remaining steps of your appeal.

It will also provide you with a better understanding of any claims decisions that you have received so far.

MASTER BENEFIT PLAN DOCUMENT

The GBP offers health, dental, vision and other optional benefits to employees, retirees and their eligible dependents. Each of these benefit plans has a detailed comprehensive written document which is referred to as the **Master Benefit Plan Document**.



The plan document has important information about how the benefit plan works, who is eligible, covered services, and participant rights and responsibilities under each plan. Another important item included in the plan document is the description of the plan's appeal process.

The plan documents are available online. You can find the specific plan information using the links below.

- **Health benefits** for medical and drug plans: Select the correct health benefit plan based on your status as an *active employee* or a *retiree*. Be sure to select the plan document for the year that corresponds with your claim, benefit coverage or appeal.



**Health
Benefits**

Active employees:

<https://www.ers.texas.gov/Active-Employees/Health-Benefits>

Retirees:

<https://www.ers.texas.gov/Retirees/Health-Benefits-for-retirees>

MASTER BENEFIT PLAN DOCUMENT

- For **optional add-on benefits** (dental, vision, disability and flexible spending account benefit options), select the correct benefit plan based on your status (active or retiree):



Optional Add-on Benefits

Active employees:

<https://www.ers.texas.gov/Active-Employees/Optional-Add-on-Benefits>

Retirees:

<https://www.ers.texas.gov/Retirees/Optional-Add-on-Benefits>



HELPFUL IDEA

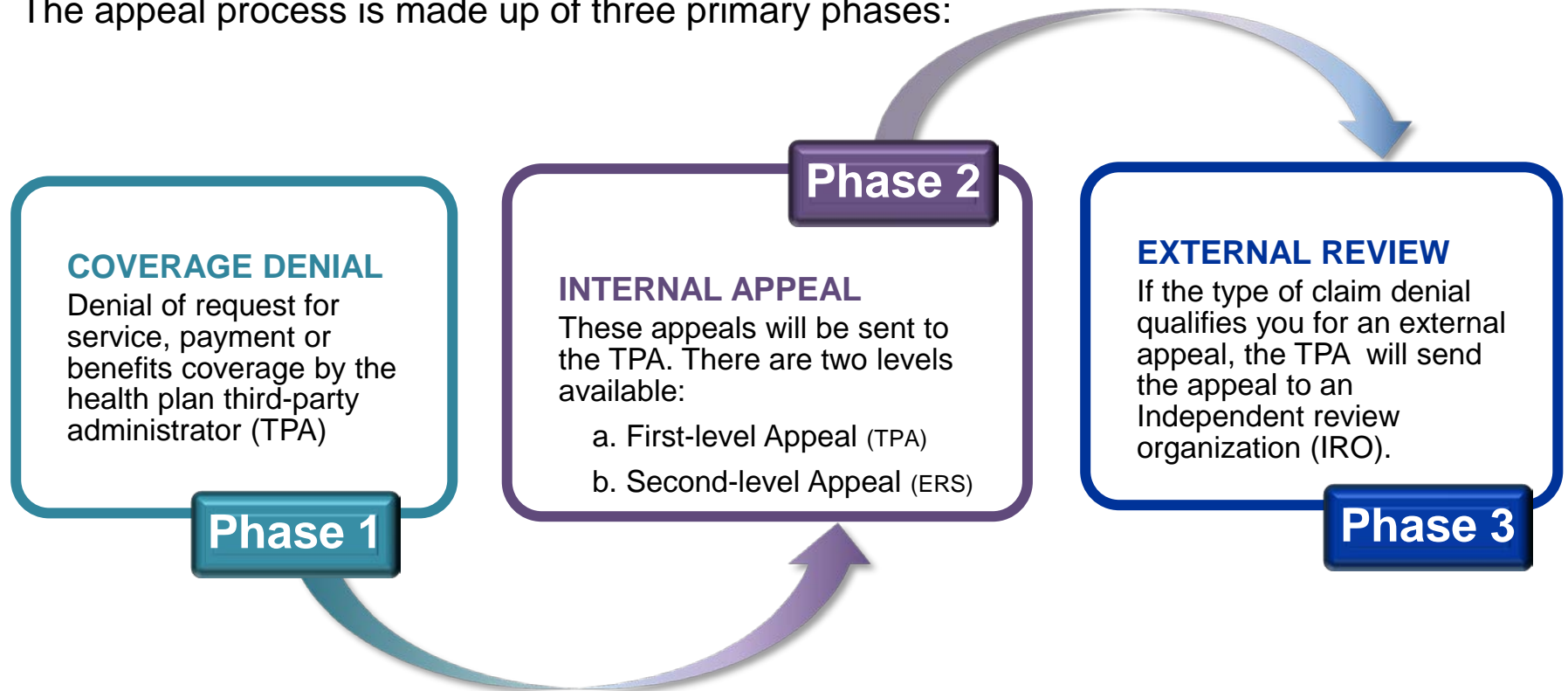
Remember to have the ERS-administered benefit program's Master Benefit Plan Document available as you review the information included in this Appeal Guide.

1

Overview of the Appeal Process for the HealthSelect of Texas and Consumer Directed HealthSelect Plans

PHASES OF THE APPEAL PROCESS

The appeal process is made up of three primary phases:



The remainder of this section of the Appeal Guide will provide an overview of the three processes: Coverage Denial, Internal Appeal and External Review. Each of the overviews is color-coded to help identify the process into the appropriate phase.

Phase 1: Green

Phase 2: Purple

Phase 3: Blue



HELPFUL IDEA

Important deadlines apply to procedures within each phase of the appeal process. It is important to submit facts, information, required documentation and additional supportive paperwork on time in each phase of the process.

We've highlighted these important deadlines throughout the Appeal Guide with this **calendar icon**.



When you see this calendar icon, it's time to mark your calendar with an important deadline.

TYPES OF COVERAGE DENIALS

Your entire request for benefits or claim – or sometimes just a part of it – may be denied for payment by the TPA. This is called a **Coverage Denial**.

COVERAGE DENIAL

Denial of request for service, payment, or benefits coverage by the health plan third-party administrator (TPA)

Phase 1

Common types of Coverage Denials include⁴:

Common Types of Coverage Denials

Urgent Care Request for Benefits (Urgent Care Request)

Your medical provider and the TPA will determine if the situation is urgent.

Pre-service Request for Benefits (Pre-service Request)

Prior authorization for services not yet received
Denial is for Pre-service Request of plan benefits.

Concurrent Care Claim

Course of treatment was previously approved (for a specific period of time or number of treatments). There is a request to extend treatment. TPA will review request for extended treatment. See MBPD for Concurrent Care Claims.

Post-service Claim

Medical services already received

⁴ ERS does not review denials of Urgent Care Requests, Pre-service Requests or Concurrent Care Claims.

PHASE 1: COVERAGE DENIAL

Let's take a look at the most common type of coverage denial, a **Post-service Claim Denial**. A **Post-service Claim Denial** occurs after you or your dependent received medical services. A medical claim is submitted, but payment for service(s) is denied.



To find the reason(s) for the denial, the best place to look is your **Explanation of Benefits**⁵ – commonly called the EOB. You will receive your EOB from Blue Cross and Blue Shield of Texas, the TPA for HealthSelect of Texas and Consumer Directed HealthSelect plans.

An EOB is provided each time a benefits claim is processed and finalized.

The EOB will include the reason(s) why any claim is denied payment⁶ and your next steps if you choose to appeal the claim denial.

Sample EOB

EXPLANATION OF BENEFITS

As EOB is a statement showing how claims were processed. This is not a bill. Your provider(s) may bill you directly for any amount you may owe. KEEP FOR YOUR RECORD.

Log in to Blue Access for Members™ at bcbtx.com to see plan and claim details or to contact us through our secure Message Center.

Have questions about the EOB? Customer Advocates are here to help! 800-488-6482

TOTAL OF CLAIM(S)

Amount billed	\$7,800.00
Discounts, reductions and payments	-\$6,140.00
You may have to pay your provider	\$1,700.00

We reviewed the claim for the patient based on the additional information received regarding other group health care coverage involvement. Blue Cross and Blue Shield has negotiated discounts with this provider. The following show how this claim was adjusted.

SUBSCRIBER INFORMATION
GROUP NAME: NONE

Member ID: BCC88899777V Group #: 00012345

SERVICE DETAIL - CLAIM (1)

PATIENT: JON SMITH PROVIDER: Ralph Johnson M.D.
SERVICE DATE: 04/02/16 CLAIM #: 012345678 Processed: 06/02/16

Service Description	Amount Billed	PLAN PROVISIONS		YOUR RESPONSIBILITY		
		Discounts and reductions	Amount covered (allowed)	Deductible and copay amount	Coinurance	Amount not covered
Surgical Charges	4,000.00	(+) 1,000.00	2,200.00	1,000.00	240.00	
Recovery Room	500.00	(+) 410.00	400.00		90.00	
Med/Surg Supplies	300.00	(+) 140.00	100.00		32.00	
Med/Surg Supplies	100.00					(-) 100.00
Laboratory Services	1,200.00	(+) 820.00	380.00		75.00	
Laboratory Services	200.00	(+) 160.00	40.00		8.00	
MRI Equipment	800.00	(+) 440.00	410.00		82.00	
Drugs	200.00	(+) 110.00	90.00		90.00	
Muscle Manipulation	100.00	(+) 90.00	90.00		10.00	
CLAIM TOTALS	\$7,800.00	\$2,930.00	\$3,830.00	\$1,050.00	\$530.00	\$100.00

SUMMARY - CLAIM (1)

PLAN PROVISIONS	YOUR RESPONSIBILITY
Amount covered (allowed)*	Deductible and copay amount
\$3,830.00	+ \$1,050.00
Deductible and copay amount	Coinurance
-\$1,050.00	+ \$530.00
Coinurance	Amount not covered
-\$50.00	+ \$100.00
Total	You may have to pay your provider
\$2,130.00	\$1,700.00

Health Care Fraud Hotline: 800-643-0987
Health care fraud affects health care costs for all of us. If you suspect any person or company of defrauding or attempting to defraud Blue Cross and Blue Shield of Texas, please call our toll-free hotline. All calls are confidential and may be made anonymously. For more information about health care fraud, please go to bcbtx.com.

Benefit Period 01-01-16 Through 12-31-16 To date this patient has met \$1,000.00 of health's \$1,000.00 Health Care Plan Deductible.

⁵ If you are being denied coverage for benefits after you received a service, you will receive an Explanation of Benefits (EOB). The EOB will state that the health service or item that your provider submitted for reimbursement is not covered by the plan. The EOB will serve as your notice of an adverse benefit determination.

⁶ The TPA must provide timely notification of a claim denial after all required information is received: 15 days for denial of a prior authorization (pre-service); 30 days for denial of medical service(s) already received (post-service); and 72-hours for denial of an urgent care request.

Post-service Claim Denial

If you have questions after reviewing the EOB

After reading your EOB, you may find it necessary to contact the TPA.



If a claim for benefits is denied in part or in whole, you may call the health plan's TPA to resolve the issue before requesting a formal appeal.

If, after calling, you are still not satisfied with the determination, you have the right to file a formal appeal. This is referred to as the First-level Internal Appeal. A First-level Internal Appeal begins Phase 2 of the process, which is described on page 22 of this Appeal Guide.

Post-service Claim Denial

If you receive the medical bill before the EOB

It is not unusual to get a bill from your provider before you receive an EOB. With the speed of today's billing systems, this can happen when an automated system generates a bill for the patient at the same time a claim is sent to the insurer for processing.

In most cases, you should wait to receive the EOB to know exactly how much the plan paid and how much you may owe the provider for your share of the service(s).

If you have questions about the amount you may owe to the provider, contact the provider's billing office.





Post-service Claim Denial

If you are going to appeal but have a medical bill due

If you disagree with the EOB and plan to appeal, talk with your provider's office if a bill is due and let them know you plan to appeal the denial. It is important to work with your provider's office to handle any outstanding bills. Your provider may also have information relevant to your appeal.

If a bill is due to a participating network provider, or an out-of-network provider, you may want to consider one of the following options:

- Ask your provider's office not to send the bill to collections (which the provider may or may not do) to allow time for the appeal.

or

- Ask to set up a payment plan, and try to negotiate the amount you owe (to avoid having the bill sent to collections).

or

- Pay the bill and request reimbursement from the provider if you win your appeal.

Post-service Claim Denial

If you received services from an out-of-network provider

If the service was provided by an out-of-network provider and the plan allows for out-of-network benefits, then the plan pays less of the allowed cost and only after you have met any applicable out-of-network deductible, copay, or coinsurance amounts. The out-of-network provider may bill you for the portion of the charges that the plan does not cover. You could also be responsible for the difference between the amount your out-of-network provider billed and the amount the plan paid. This amount is referred to as **balance billing**.

If you are balance billed by an out-of-network provider, you may want to consider one of the following steps⁷.

- Ask the provider to reduce or waive the balance billed amount.
- or
- Request a payment plan.

Mediation is available for certain out-of-network provider bills of \$500 or more. Additional information about the mediation rights is available on page 29 of this document.

⁷ ERS cannot recommend either option. You must decide what is best for your specific situation.

PHASE 2: FIRST-LEVEL INTERNAL APPEAL

Start your First-level Internal Appeal by carefully following the instructions included on the EOB that you received from the health plan.

The EOB will say if you can simply call to appeal the claim. If not, and you are asked to mail information, complete all forms and provide all documents required by the TPA or write to the TPA and include your name, claim number and health insurance ID number.

Phase 2

INTERNAL APPEAL

These appeals will be sent to the TPA. There are 2 levels available:

- ▶ a. **First Level Appeal**
- ▶ b. Second Level Appeal

- ✓ Provide all of the factual and important information that you want the health plan's TPA to consider.
- ✓ Include information that supports your appeal – like a letter from your doctor, a treatment plan, your relevant medical records, and any correspondence or notes from phone calls you have had with the health plan's TPA.



For Urgent Care Request, Pre-service Request (prior authorization), and Post-service Claim (medical services already received) denials, you **must file your written internal appeal with the TPA within 180 days** of receiving notice that your request for benefits or initial claim was denied.

PHASE 2: FIRST-LEVEL INTERNAL APPEAL

First-level Internal Appeal: Decision Letter

The TPA must provide you with timely written notification of its decision.

- 72 hours for an appeal of an Urgent Care Request
- 15 days for an appeal of a Pre-service Request (prior authorization)
- 30 days for an appeal of a Post-service Claim for medical services already received

If your First-level Internal Appeal is **successful**, you will receive written notice from the TPA that your service or item will be covered.

If your First-level Internal Appeal is **unsuccessful**, you will receive a written notice from the TPA explaining the reason(s) the TPA upheld the denial of coverage.

PHASE 2: FIRST-LEVEL INTERNAL APPEAL

There are many reasons a First-level Internal Appeal may be unsuccessful. Common examples include that the member did not get a prior authorization or referral to a specialist when one was required by the plan.

- If you do not have the right to an additional appeal (for example, if your appeal was not filed in a timely way and you were unable to show good cause for missing the deadline), the First-level Internal Appeal is the last step in the process. The decision is final.
- Read the decision letter carefully. An additional appeal may be available to you, but important deadlines apply. If so, the decision letter will provide instructions for how to continue the appeal process to a Second-level Internal Appeal.

PHASE 2: SECOND-LEVEL INTERNAL APPEAL

Continuing to Second-level Internal Appeal process

If you choose to continue your appeal past the First-level Internal Appeal decision, and have the right to do so, you will move on to the Second-level Internal Appeal process.

Your decision letter will give you instructions about the type of appeal, including where to send a Second-level Internal Appeal request and the applicable due dates.

Phase 2

INTERNAL APPEAL

These appeals will be sent to the TPA. There are 2 levels available:

- ▶ a. First Level Appeal
- ▶ **b. Second Level Appeal**

PHASE 2: SECOND-LEVEL INTERNAL APPEAL

Where to send your Second-level Internal Appeal request:

- A Second-level, *Pre-service Appeal* will be sent to the TPA. The mailing address is provided in the First-level Internal Appeal decision letter.
- A Second-level, *Post-service Appeal* will be sent to ERS. The mailing address is provided in the First-level Internal Appeal decision letter. Do not submit these appeals to the TPA as that may negatively impact the timeliness of your appeal.

When you must file your Second Level Internal Appeal:



- A Second-level Urgent Care Request, Pre-service Request or Concurrent Care Claim Appeal must be filed in writing with the TPA within **60 days** from your receipt of the First-level Internal Appeal decision letter.
- A Second-level, Post-service Claim Appeal must be signed and filed in writing with ERS within **90 days** from your receipt of the First-level Internal Appeal decision letter.

PHASE 2: SECOND-LEVEL INTERNAL APPEAL

Determination letter

The plan must provide you with timely written notification of its determination.

- Within 15 days for an appeal of an Urgent Care Request
- Within 15 days for an appeal of a Pre-service Request (prior authorization)
- Within 30 days for an appeal of a Post-service Claim for medical services already received

If your Second-level Internal Appeal is **successful**, you will receive written notice from the plan that your service or item will be covered.

If your appeal of a Post-service Claim is **unsuccessful**, you will receive a written determination from the plan that explains the reason(s) for upholding the denial of coverage.

PHASE 2: SECOND-LEVEL INTERNAL APPEAL

There are many reasons a Second-level Internal Appeal may be unsuccessful. Common examples of unsuccessful Second-level Internal Appeals are included in the Summary of Determinations later in this Appeal Guide.

- If you do not have the right to an additional appeal, then the Second-level Internal Appeal is the last step in the process. The decision is final.
- If you do have the right to an additional appeal, the Second-level Internal Appeal determination letter will provide instructions for how to continue the appeal, but important deadlines apply. You may be eligible for an External Review of your appeal.

Information on the External Review phase begins on page 31 of this Appeal Guide.

MEDIATION RIGHTS

Mediation legislation was updated January 1, 2018. Mediation through the Texas Department of Insurance (TDI) may lower the amount you owe for certain out-of-network medical services you received.

You may be eligible for mediation when:

- you have had an unsuccessful Second-level Internal Appeal;
- you have received emergency care, health care or medical services or supplies from a facility, emergency care provider or facility-based provider that is an out-of-network provider; and
- you receive a bill from the out-of-network provider for \$500 or more after applicable out-of-pocket costs (copays, coinsurance and deductibles).



HELPFUL IDEA

Check your EOB for important information about any mediation available to you.

MEDIATION RIGHTS

REQUESTING MEDIATION

If you are eligible, you may request mediation through the Texas Department of Insurance (TDI). Additional information about the mediation process is available on the [TDI website](#).

You will need to file a Health Insurance Mediation Request Form directly with TDI, not ERS, at www.tdi.texas.gov/consumer/cpmmediation.html or by calling (800) 252-3439, toll-free, to request a form.



HELPFUL IDEA

To learn more or request mediation, call the TDI Consumer Help Line toll-free at (800) 252-3439 or visit TDI's website:

<http://www.tdi.texas.gov/consumer/cpmmediation.html>

PHASE 3: EXTERNAL REVIEW

EXTERNAL REVIEW

If the type of claim denial qualifies you for an external appeal, the TPA will send the appeal to an Independent Review Organization (IRO)

Phase 3

You may be entitled to request an External Review by an independent review organization (IRO).

An External Review may be available if an unsuccessful Second-level Internal Appeal is related to care involving a question of medical judgment, or a question of whether appropriate internal claims and appeal processes were followed.

If you have the right to an External Review, you will be notified by ERS or the TPA.

- The external review is available at no charge to you.
- An external review either upholds the denial or overturns all or part of the denial.
- The external review decision is final for both you and the health plan. You and the TPA are bound by the external review decision.

PHASE 3: EXTERNAL REVIEW

There are two types of External Reviews⁸:

- Standard External Review
- and
- Expedited External Review

The most important difference between the two is that the time periods for completing certain portions of the review process are much shorter in the Expedited External Review than in the Standard External Review.

⁸ Refer to the Master Benefit Plan Document's Claims Procedures Section (External Review Program) for specific information about External Reviews.

PHASE 3: EXTERNAL REVIEW

Standard External Review

Important deadlines apply throughout the Standard External Review.

- You must submit a request for an external review within **four (4) months** of the date you received notice denying your Second-level Internal Appeal.
- Within five (5) business days of receiving your request for an External Review, the TPA will determine the following:
 - whether you were covered by the plan when the service or procedure under review was provided;
 - whether you have additional applicable internal appeals available; and
 - whether you have provided all information and forms required to move forward.



After the review is completed, a written response will be provided to you.

PHASE 3: EXTERNAL REVIEW

Standard External Review

If you are eligible for an External Review, the plan will provide the IRO with the documents and information used to make the previous denial determination.

You and your provider may submit additional information or evidence to support your position in the External Review. Any additional information that you want the IRO to consider must be submitted in writing to the IRO within **10 business days** following the date you receive notice from the IRO.



The IRO will provide both you and the TPA with written notice of its determination within 45 days of receiving the request for review.

- If the IRO decides to reverse the denial, the TPA will provide coverage or payment of the benefits as required in the final External Review decision.
- If the IRO upholds the denial, the TPA will not be obligated to provide benefits for the service or procedure, and you have exhausted your appeal rights.

All final External Review decisions by an IRO are final and binding on all parties and not subject to further appeal rights.

PHASE 3: EXTERNAL REVIEW

Standard External Review



HELPFUL IDEA

Refer to the **Master Benefit Plan Document's** Claims Procedures Section (External Review Program) for specific information about External Reviews.

PHASE 3: EXTERNAL REVIEW

Expedited External Review

You may make a written or verbal request for an Expedited External Review if:

- your benefits were denied and
- your appeal involves a medical condition for which the time it takes to complete a Standard External Review would, according to your doctor, seriously jeopardize your life or health or jeopardize the your ability to regain maximum function; and
- you have filed a request for an Expedited Internal Appeal, which is generally handled by the health care provider. Instructions for an Expedited Internal Appeal can be found in the Prior Authorization denial letter.

An Expedited External Review may also be available if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which you received emergency services, but you have not been discharged from a facility.



HELPFUL IDEA

Refer to the **Master Benefit Plan Document's** Claims Procedures Section (External Review Program) for specific information about Expedited External Reviews.

PHASE 3: EXTERNAL REVIEW

Expedited External Review

Immediately upon receiving your request for an Expedited External Review, the TPA will determine the following:

- whether you were covered by the plan when the service or procedure in question was provided and
- whether you have provided all information and forms required to move forward.

After completing the review, the TPA will provide a written response to let you know if you are eligible for an Expedited External Review.

If your request is eligible, the TPA will immediately provide the IRO with the documents and information used in making their determination.

The IRO will provide notice of the final External Review decision for an Expedited External Review as quickly as your medical condition or the circumstances require, but no more than 72 hours after the IRO receives the request.

All final External Review decisions by an IRO are final and binding on all parties and not subject to further appeal rights.

2

Summary of ERS Appeal Determinations

HOW TO USE THE APPEAL DETERMINATIONS SUMMARY



1. **Better understand and get the most of your benefits!**

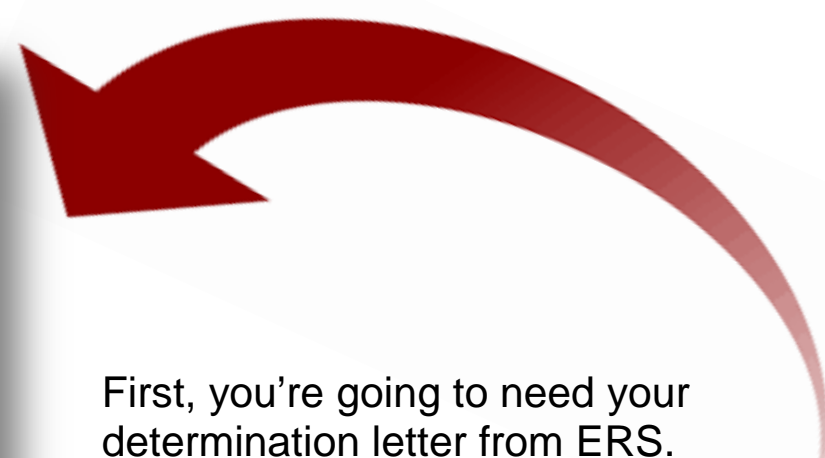
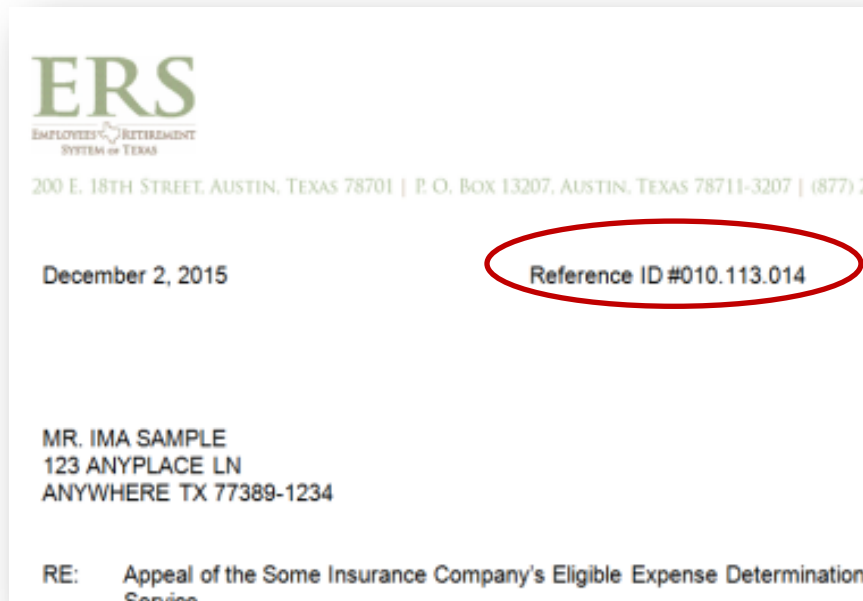
This section of the Appeal Guide is both an educational tool and an illustration of medical claims with Second-level Appeals submitted to ERS. We want you to understand why a claim may be denied, to help you make informed choices. This helps make you a more informed health care consumer!

Just as most people have different medical needs, most appeals are different enough that the appeals outcomes vary. Rest assured that your plan conducts a fair and impartial review of each appeal to ensure that all appeals are treated consistently, accurately and fairly.

HOW TO USE THE APPEAL DETERMINATIONS SUMMARY

2. Better understand your Second-level Appeal determination letter.

Did you receive a Second-level Appeal determination letter from ERS and you're not quite sure what it means? This section of the Appeal Guide will help you better understand the reasons for the decision about your claim or coverage.



First, you're going to need your determination letter from ERS.

Now, find your letter's Reference ID #, to the right of the date at the top.

HOW TO USE THE APPEAL DETERMINATIONS SUMMARY

Use the Reference ID # to identify a similar scenario in the following pages.



SUMMARY OF ERS APPEAL DETERMINATIONS			
Benefit Plans ¹⁰	Grievance Issue	Things to Know Reference ID# 010.113.###.### See pp.35-36 of this GUIDE on using the Reference ID	General Outcome
HealthSelect of Texas Consumer Directed HealthSelect	Out-of-network ¹¹ denials (Out-of-network allowable amount)	<p>TYPES OF OUT OF NETWORK CLAIM DENIALS</p> <p>1. Balance Billing Letter's Reference ID# begins 010.113.###.###</p> <p>What is Balance Billing?</p> <p>Balance billing refers to the amount an out-of-network provider bills you above the amount of your co-share (co-pay, co-insurance, or deductible) under the plan. It is the difference between (1) the out-of-network provider's billed charge and (2) the amount paid by the plan plus the amount of your co-share. Balance billing can result in significant increased cost to you. Balance billing amounts do not count toward or apply to any out-of-pocket maximum.</p> <p>For example, the Non-Network provider's billed charge is \$1,500 and the allowable amount is \$100.</p>	<p>Out-of-network allowable amounts are determined by the health plan and are not subject to change based on appeal. If an appeal results in a discovery that the incorrect allowable amount has been applied, then the benefit will be recalculated, as appropriate.</p> <p>Network Providers do not always balance</p>

As a reminder, the specific facts of each appeal can lead to a unique outcome. Carefully read the *Things to Know* and the *FAQs* to better understand the outcome of your appeal.

SUMMARY OF ERS APPEAL DETERMINATIONS

Benefit Plans ⁹	Grievance Issue	Things to Know Reference ID # See page 40 of this guide for how to use the Reference ID #.	General Outcome
HealthSelect of Texas Consumer Directed HealthSelect	Out-of-network denials	<p>TYPES OF OUT-OF-NETWORK CLAIM DENIALS</p> <p>Balance billing Letter's Reference ID# begins 010.113. ###.###</p> <p>What is balance billing? Balance billing refers to the amount an out-of-network provider bills you above the amount of your co-share (copay, coinsurance or deductible) under the plan.</p> <p>It is the difference between (1) the out-of-network provider's billed charge and (2) the amount paid by the plan plus the amount of your co-share. Balance billing can result in significant increased cost to you. Balance billed amounts do not count toward or apply to any out-of-pocket maximum.</p> <p>For example, the out-of-network provider's billed charge is \$1,500 and the allowable amount is \$100.</p> <p>The plan pays \$60 toward the cost of this claim (\$100 allowable x 60% out-of-network benefit, assuming the out-of-network deductible is met). You are responsible for the</p>	<p><i>Balance billing</i> Out-of-network providers do not always balance bill you for differences between the billed and allowable amounts. However, out-of-network providers may balance bill you, and the TPA cannot prevent them from doing so.</p> <p><i>Mediation rights</i> You may have mediation rights in connection with a balance bill, but that process is not addressed through an appeal to the health plan.</p> <p>See Mediation Rights beginning on page 29 of this Guide.</p>

⁹ As a state governmental plan, the Texas Employees Group Benefits Program (GBP), including the health benefit plans offered, is not subject to the federal Employee Retirement Income Security Act of 1974 (ERISA).

		<p>remaining 40% or \$40. The out-of-network provider may then bill you for the remaining \$1,400 (balance-billed amount).</p> <p>Note: A participating network provider may not balance bill you.</p> <p>What is an allowable amount?¹⁰</p> <p>The allowable amount is the maximum benefit that is paid for a covered service. Sometimes this is called the “eligible expense” or “payment allowance.”</p> <p>For services provided by out-of-network providers, the allowable amount is typically lower than the allowable amount for services provided by network providers for the same service. Once the out-of-network allowable amount is determined, the out-of-network benefit is applied. This generally results in a limited reimbursement amount to the provider and sometimes results in the provider balance billing the participant, because the out-of-network benefit level is not based on the billed amount; it is based on the lower out-of-network provider allowable amount.</p>	<p><i>Out-of-network allowable amount</i></p> <p>Out-of-network allowable amounts are determined by the TPA and are not subject to change based on appeal.</p> <p><i>Incorrect allowable amount applied</i></p> <p>If it is discovered during an appeal that an incorrect allowable amount has been applied, the benefit will be recalculated, as appropriate.</p>
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¹⁰ Refer to the Master Benefit Plan Document for specific information about network benefits, out-of-network benefits and allowable amounts.

EXAMPLE 1

Out-of-network doctor billed \$10,000 for a covered service delivered at the doctor’s office.

Because services were provided by an out-of-network provider, the out-of-network benefit level applies (60% of allowable amount after the deductible is met). The allowable amount is \$850; this means that the combined amount paid by the plan and the patient will be \$850.

\$10,000.00 Billed amount

850 Allowable amount
- 0 Amount applied to deductible

In this example, the annual deductible has been met, so the amount is \$0. If the annual deductible had not been met, the unmet portion would be subtracted here.

\$ 850
X 60% Out-of-network benefit

\$ 510 Plan paid (\$850 x 60%)

Patient is responsible for \$340 (\$850 x 40%).

Patient appealed the amount of plan reimbursement, which was \$510.

Balance billed amount

Patient received a bill for \$9,150 because the out-of-network provider balance billed the difference between the billed charges (\$10,000) and the amount paid by the plan (\$510) and the patient (\$340): $\$10,000 - \$510 - \$340 = \$9,150$.

Example 1 illustrates how the out-of-network benefit works when you see an out-of-network provider in an office setting.

The claim for the office visit will be paid at out-of-network benefits because the provider is out-of-network. This means that the patient will be responsible for meeting the out-of-network deductible and coinsurance.

The patient could also be balance billed the difference between the provider’s charges and the amount paid by the plan.

EXAMPLE 2

An out-of-network, hospital-based provider -- such as an anesthesiologist, assistant surgeon, ER physician, surgical assistant, lab technician, radiologist or pathologist -- billed \$10,000 for a covered service delivered at a participating network facility like a hospital or surgical center.

Because the services were provided by the out-of-network hospital-based provider at a participating network facility, the network benefit level applies (80% of allowable amount).

\$10,000	Billed amount
850	Allowable amount
- 0	Applied to deductible

In this example the annual deductible has been met, so the amount is \$0. If the deductible had not been met, the unmet portion would be subtracted here.

\$ 850	
X 80%	Network benefit
\$ 680	Plan paid (\$850 x 80%)

Patient is responsible for \$170 (\$850 x 20%).

Patient appealed the amount of plan reimbursement, which was \$680.

Balance billed amount

Patient received a bill for \$9,150 because the out-of-network provider billed patient the difference between the billed charges (\$10,000) and the amount paid by the plan (\$680) and the

Example 2 illustrates how the benefit for out-of-network hospital-based physicians works when a surgery is performed in a network facility.

The patient elects to have surgery at a network hospital and the required prior authorization is approved.

During the procedure, an out-of-network, hospital-based anesthesiologist provides services. Because the out-of-network anesthesiologist is based at a network hospital, the anesthesiologist's claim will be processed at the network benefit level: the plan pays 80% coinsurance and the patient is responsible for the remaining 20%.

However, the anesthesiologist will be reimbursed using the out-of-network allowable

		<p>patient (\$170): $\\$10,000 - \\$680 - \\$170 = \\$9,150$.</p> <p>The network benefit level applies in this example because the provider was based at a network hospital.</p>	<p>amount and can still bill the patient the difference between the billed charges and the amount paid by the plan.</p> <p>If the patient is balance billed, they may have the right to mediation. See Mediation Rights description in Section 1 of this document.</p>
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Frequently Asked Question (FAQ): Out-of-network Denials

I was not aware that my doctor was not in the network. Now I am getting bills that I cannot afford and my plan denied additional payment. What can I do?

Your plan wants doctors in its network; however, not all doctors will agree to participate. You should always check in advance to make sure your doctor is in the network.

There are several ways to get help in finding a network provider:

- Speak with a Blue Cross and Blue Shield of Texas Personal Health Assistant at (800) 252-8039.
- Use the [HealthSelect provider](https://healthselect.bcbstx.com/content/find-a-doctor-hospital/index) finder at <https://healthselect.bcbstx.com/content/find-a-doctor-hospital/index>.
- Ask your doctors if they participate in the network.

It can be challenging to find out whether one or more of the providers on your care team will be in the network at the time you receive services, even when you ask in advance, and particularly if you are having a surgical procedure.

This is one of the reasons the TPA gives network benefits for services received from an out-of-network, hospital-based provider at a network facility. This does not prevent the out-of-network provider from balance billing you, but you may be eligible for mediation if that out-of-network provider balance bills you more than \$500.

For more information see **Mediation Rights** in Section 1 of this Appeal Guide.

If the plan denied additional payment, you do have some options.

- Start with checking if your claim is eligible for mediation. Your appeal response letter will advise you if mediation is available to you.
- Try to negotiate directly with your doctor's office or work out a payment plan. Many out-of-network doctors will work with you.
- Contact the doctor's office.
 - Ask them not to send the bill to collections (which the provider may or may not do) to allow time for the appeal.
 - Ask to set up a payment plan, and try to negotiate the amount you owe (to avoid having the bill sent to collections).
 - Pay the bill and request reimbursement from your provider if you win your appeal.

SUMMARY OF ERS APPEAL DETERMINATIONS

Benefit Plans	Grievance Issue	Things to Know Reference ID # _____ See page 40 of this guide for how to use the Reference ID #.	General Outcome
HealthSelect of Texas Consumer Directed HealthSelect	Freestanding emergency room	<p>What is a freestanding emergency room?¹¹</p> <p>A freestanding emergency room (FSER) is a medical care facility that is structurally separate and distinct from a hospital, which is not affiliated with a hospital and is not a hospital's emergency room department, and which receives an individual and provides emergency care. These independent emergency centers are owned by independent groups or individuals, not a hospital system. Some FSERs are network facilities, but some are out-of-network.</p> <p>Plan's benefit design for <i>out-of-network</i> FSERs¹²</p> <p>As of January 1, 2018, HealthSelect plans no longer pay the amount billed by an out-of-network FSER as they did in the past — even if the care is due to a true emergency. The plans now pay a portion of the allowable amount for services received. The plan's benefit is now based on the <u>allowable amount</u> which is <u>lower than the billed amount</u>. This means that patients are responsible for a larger portion of an out-of-network FSER bill. This is true whether the services were the result of a true emergency or out-of-</p>	<p><i>Mediation rights</i></p> <p>You may have mediation rights in connection with a balance bill for service from an out-of-network FSER, but that process is not addressed through an appeal to the health plan.</p> <p>If you get a bill that is more than \$500 (not including copay, coinsurance and deductible), for emergency care, health care, medical</p>

¹¹ Refer to the Master Benefit Plan Document for specific information about freestanding emergency room (FSER) facilities, as well as an explanation of the difference between a FSER and a freestanding emergency department that is affiliated with a hospital.

¹² Refer to the ERS publication [Higher HealthSelect costs for out-of-network freestanding ERS: Know your options – and the costs – for urgent and emergency care](https://www.ers.texas.gov/HealthSelect-freestanding-ERS) at <https://www.ers.texas.gov/HealthSelect-freestanding-ERS>.

		<p>emergency.</p> <p>For the HealthSelect of Texas plan, a visit to an out-of-network FSER also requires a higher copayment than a visit to a network FSER, or a network or out-of-network freestanding emergency department that is affiliated with a hospital.</p> <p>Mediation rights</p> <p>As of January 1, 2018, if you visit any out-of-network emergency facility -- such as an out-of-network hospital emergency room or out-of-network freestanding ER, whether it is affiliated with a hospital or not -- or you get services from an out-of-network hospital-based health care provider at a network facility, and you get a bill for \$500 or more (not including your copay, coinsurance and deductible), you have the right to dispute the billed amount and ask for mediation.</p> <p>More information about mediation is available from the Texas Department of Insurance. Call (800) 252-3439 or access their website www.tdi.texas.gov/consumer/cpmmediation.html</p>	<p>services or supplies from a facility, emergency care provider or facility-based provider that is out-of-network, you may have the right to Mediation.</p> <p>See Mediation Rights beginning on page 29 of this Appeal Guide.</p>
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Frequently Asked Question (FAQ): Freestanding ERs

I think I have been unfairly billed for my emergency care. What can I do?

Emergency health care providers in Texas are required to notify you of your mediation rights if you are balance billed by the emergency provider \$500 or more after applicable out-of-pocket costs (copays, coinsurance and deductibles), for services provided on or after January 1, 2018. To learn more contact the Texas Department of Insurance at (800) 252-3439 or access their website regarding mediation for a health insurance claim at www.tdi.texas.gov/consumer/cpmmediation.html.

SUMMARY OF ERS APPEAL DETERMINATIONS

Benefit Plans	Grievance Issue	Things to Know Reference ID # _____ See page 40 of this guide on using the Reference ID #.	General Outcome
HealthSelect of Texas ¹³	No specialist referral	<p>Why do I need a referral?</p> <p>HealthSelect of Texas is a point-of-service plan. This is a type of managed care health insurance plan in which you must choose a primary care physician (PCP) who is responsible for coordinating your care and referrals to most specialists.¹⁴ You will receive the highest benefit levels (that is, the plan will pay the most for covered services) when you use network providers.¹⁵</p> <p>When do I need a referral?</p> <p>Get a referral from your network PCP before you visit any network specialist. If you see a network specialist without a valid referral from your PCP, you will receive out-of-network benefits. Out-of-network benefits will apply to all related services received without the required referral, including any inpatient hospital stay.</p> <p><i>An informal referral or a recommendation from a provider that has not been approved by the TPA – even if it is in writing – will</i></p>	<p>The plan will uphold a denial of benefits if you have not obtained a required referral.</p> <p>The list of services that requires a referral from your PCP is determined by the TPA and is not subject to change based on appeal.</p> <p>If an appeal results in a discovery that a referral was obtained (or not needed), the appropriate benefit will be applied.</p>

¹³ Consumer Directed HealthSelect, HealthSelect Out-of-State and HealthSelect Secondary participants do not have to choose a primary care physician (PCP) and don't have to get referrals to see specialists.

¹⁴ Visits to certain specialist providers do not require a referral from your PCP. Refer to the Master Benefit Plan Document for specific information about providers that may be seen without a referral from your PCP.

¹⁵ Refer to the ERS' publication [HealthSelect costs are higher for out-of-network care: Find out how going out of network can cost you more](https://www.ers.texas.gov/Active-Employees/News-About-Your-Benefits/HealthSelect-costs-are-higher-for-out-of-network-care) at <https://www.ers.texas.gov/Active-Employees/News-About-Your-Benefits/HealthSelect-costs-are-higher-for-out-of-network-care>.

		<p><i>not be valid to receive network benefits.</i></p> <p>See Section 3 of the MBPD, How the Plan Works, for more information on referrals and network benefits.</p> <p>Advantages of using network providers</p> <ul style="list-style-type: none">• Network providers have contracted rates to keep costs low – both plan costs and your costs.• Using network providers can help reduce your out-of-pocket costs. The copay required to see a network provider is usually lower than the coinsurance amount required to see an out-of-network provider.• There is no annual medical deductible if you stay in the HealthSelect network.• If you use a network provider, you cannot be balance billed.	
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Frequently Asked Questions (FAQs): No Specialist Referral

1. I did not get a referral from my PCP before seeing my ophthalmologist. Will my claim be denied?

A referral is not needed for services provided by an ophthalmologist. This is one of the specialists for whom you don't need a referral.

2. Are there other types of providers that do not need a referral?

Section 3 of your Master Benefit Plan Document, Selecting a Primary Care Physician (PCP), has a list of providers that may be seen without a referral from your PCP.

Provider services that do not require a referral include:

- Ob/gyn services;
- chiropractic visits;
- eye exams (both routine and diagnostic);
- mental health counseling;
- occupational therapy and physical therapy;
- virtual visits, urgent care centers and retail health clinics; and
- emergency facilities.

Refer to the MBPD for the most current list of provider services that do not require a referral.

Keep in mind that even if you don't need a referral, you should see network providers for the highest level of benefit. Also, you might need prior authorization for some of the services these providers recommend.

3. I called my PCP to get a referral, but s/he did not send it and the claim was denied. What should I do?

In a case like this, you should consider appealing the claim, providing as much detail as possible. The plan's third-party administrator will investigate to determine what happened, including any missteps that were not under your control. The plan will consider all information available to determine your appeal.

4. My PCP referred me to a specialist, and that specialist has referred me to another specialist. Is the original referral enough, or will my claim be denied?

In most cases, a specialist cannot provide a referral for you to another provider. If you do not have a referral from your PCP on file before you see a specialist, you will pay more, because your visit will be considered out-of-network even if the specialist is a network provider.

5. I've been seeing my specialist for a long time, and my referral expired without my knowing it. I've been receiving the same care from the same network specialist. Is my claim now going to be denied?

In most cases, a referral is good for 12 months. If you don't get a referral before you receive services, you will get out-of-network benefits. This includes services you have been regularly receiving. Your PCP must confirm the continued need and provide periodic referrals for you to continue seeing that specialist.

SUMMARY OF ERS APPEAL DETERMINATIONS

Benefit Plans	Grievance Issue	Things to Know Reference ID # _____ See page 40 of this guide on how to use the Reference ID #.	General Outcome
HealthSelect of Texas Consumer Directed HealthSelect	Exclusions	<p>What is an exclusion?</p> <p>Exclusions are services that the plan does not cover.</p> <p>The plan does not pay benefits for excluded services, treatments or supplies -- even if they are recommended or prescribed by a provider, are the only available treatment for your condition, or are determined by the TPA to be medically necessary. You are solely responsible for payment of charges for all services, treatments and supplies excluded by the plan.</p> <ul style="list-style-type: none"> • Section 7 of the Master Benefit Plan Document for HealthSelect of Texas provides a list/description of services, supplies and treatments categorized as Exclusions, which are not Covered Health Services under the plan. • Section 7 of the Master Benefit Plan Document for Consumer Directed HealthSelect provides a list/description of services, supplies and treatments categorized as “Exclusions,” which are not “Covered Health Services” under the plan. 	<p>The plan will overturn a denial if it determines that your service was mistakenly categorized as excluded. Generally, if the plan determines that your service was excluded from coverage, then the denial will be upheld and you have no further right to appeal the denial.</p> <p>If the plan determines that your service is excluded because it is <i>experimental or not medically necessary</i> you may have the right to an external appeal to an IRO after all internal appeals are complete.</p>

Frequently Asked Questions (FAQs): Exclusions¹⁶

1. My EOB states that the service ordered by my doctor is excluded and not covered by the plan. I trust my doctor and think it should be covered. What should I do?

Exclusions are not covered by the health plan, even if they are recommended by your provider. You may appeal the determination, but the plan will overturn the TPA's denial only if it determines that your service was mistakenly categorized as excluded. Generally, if the plan determines that your service is in fact excluded, then you have no further right to appeal the determination beyond a Second-level Internal Appeal (if one is filed in a timely way).

2. My EOB states that the service ordered by my doctor is considered experimental and not covered by the plan. I trust my doctor and think it should be covered. Does it make a difference if the exclusion is due to the service being considered experimental?

Although the plan does exclude experimental services, there is an additional consideration in these cases. If the plan determines during a Second-level Internal Appeal that your service is excluded because it is experimental, you have the right to an External Review by an IRO. This is because the IRO may determine that, based on its medical judgment, the service was not experimental.

¹⁶ Refer to the Master Benefit Plan Document for the appropriate benefit plan regarding specific information on your benefit plan's exclusions.

3. My EOB states that the service ordered by my doctor is considered not medically necessary and, therefore, not covered by the plan. I trust my doctor and think it should be covered. What if the exclusion is because the medical services are considered not medically necessary?

Although the plan does exclude services that are not medically necessary, there is an additional consideration in these cases. If the plan determines during a Second-level Internal Appeal that your service was excluded because it is not medically necessary, you may have the right to an External Review by an IRO.¹⁷ This is because the IRO may determine that, based on its medical judgment, the service was medically necessary.

External review by an IRO is available for claim denials that involve questions of medical judgment, except when the service or procedure is *excluded even if it is medically necessary*. For example, the plan excludes services that are medically necessary to correct an injury or defect from a prior cosmetic surgery that was, itself, excluded. See Section 7, Exclusions, of the MBPD.

¹⁷ Refer to the Master Benefit Plan Document's Claims Procedures Section (External Review Program) for specific information about External Reviews.

SUMMARY OF ERS APPEAL DETERMINATIONS

Benefit Plans	Grievance Issue	Things to Know Reference ID # _____ See page 40 of this guide on using the Reference ID #.	General Outcome
HealthSelect of Texas Consumer Directed HealthSelect	Appeal received after the deadline	<p>What are the deadlines?</p> <p>The deadlines for the claims appeal process differ based on the type of claim you are appealing. The maximum time limits for each step of the medical claim appeal process are federally mandated.</p> <p>Page 14 of this Appeal Guide provides a general summary of the different phases of the appeal process.¹⁸</p> <p>What are the different types of appeals?</p> <ul style="list-style-type: none"> • Post-service Appeal for the denial of a service or item you have already received or for the cancellation of coverage • Pre-service Standard Appeal for the denial of a service you have not yet received • Pre-service Expedited Appeal for the denial of an Urgent Care Request for a service you have not yet received <p>A denial of benefits for medical services does not mean that you</p>	<p>Appeals that were not filed in time will not be considered unless you show good cause¹⁹ for having missed your deadline.</p> <p>If the TPA determines that you demonstrated good cause for missing the filing deadline, your appeal will move forward.</p>

¹⁸ Please refer to the plan's Master Benefit Plan Document's Claims Procedures Section for specific information about timing and deadlines related to phases of an appeal.

¹⁹ Texas Employees Group Benefits Act, Section 1551.003(9-a) "Good cause" means that a person's failure to act was not because of a lack of due diligence the exercise of which would have caused a reasonable person to take prompt and timely action. A failure to act based on ignorance of the law or facts reasonably discoverable through the exercise of due diligence does not constitute good cause.

		<p>cannot receive the medical services you seek.</p> <p>The denial of benefits means that the medical services will not be covered under the plan and no payments will be made to you or any providers by the plan if you receive the denied medical services, unless the denial is reversed through a subsequent appeal.</p>	
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Frequently Asked Question (FAQ): Appeal received after the deadline (untimely appeal filing)

My appeal was denied for untimely filing. I admit I was late, but is there anything I can do now?

Please refer to your appeal denial letter. If you encountered special circumstances that made it difficult for you to meet the deadline, you may submit information about those issues for consideration as outlined in the letter. You will have to show good cause for having filed an untimely appeal.