South Carolina

BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association

Provider Appeals

Physicians and physician groups may file a provider appeal if they disagree with BlueCross' adjudication of a claim. Before requesting an internal post-service appeal, the physician shall use his or her best efforts to first get written authorization to proceed as the representative of the member. If the physician gets consent to proceed on behalf of the member, then the physician's appeal rights are those of the member and the physician is bound by the decision rendered in the member's appeal process.

We shall adjudicate all internal post-service appeals that physicians file within the time limits established under the Department of Labor regulations, regardless of whether ERISA applies.

Here are some reasons you may want to file an appeal:

- If you think we did not apply coding and payment rules correctly.
- If you disagree with our interpretation of medical necessity.
- If you disagree with our denial of a claim for post-service issues that may either be the responsibility of the provider or the member.

You can not appeal any issues that are considered member benefit or contractual issues. Here are some examples of reviews that you can not appeal on your own behalf:

- Deductible/coinsurance issues.
- Benefit limitations.
- Benefit exclusions.
- Membership issues.

Provider Appeal Process for Medical Necessity and Billing/Coding Disputes

The provider appeal process for **medical necessity** applies to adjudicated claims related to:

- Medical necessity determinations.
- Cosmetic services.
- Investigational/experimental services.
- No authorization for inpatient stay.

The provider appeal process for **billing or coding** applies to adjudicated claims related to:

- Integral part of primary service
- Mutually exclusive services
- Services not eligible for separate reimbursement
- Incidental denials
- Surgical global denials
- Second surgery denials

You can pursue a provider appeal for billing or coding disputes and medical necessity determinations by sending a written request for appeals using the Medical Review Request Form. You must attach supporting medical information to the form and fax it to the appropriate department within 180 days of the date we originally adjudicated the claim.

After reviewing the reconsideration, we will decide whether the initial decision should be affirmed, dismissed or reversed. If the initial adverse determination is upheld through the internal appeals process, you can seek an external review through an independent review organization. You can submit a written request for external review within 60 days from the date of the internal post service appeal denial decision.

BlueCross established the physician billing/coding dispute process for class members disputing coding and payment methodologies. Physicians and physician groups covered by the settlement may submit billing disputes as defined and directed in the settlement agreement using the Physician Billing/Coding Dispute Form within 60 days after exhausting BlueCross's internal appeals process.