BlueCross BlueShield of South Carolina and
BlueChoice® HealthPlan of South Carolina

Independent licensees of the Blue Cross and Blue Shield Association

Provider Reconsiderations

BlueCross BlueShield of South Carolina and BlueChoice HealthPlan accept provider reconsideration requests to review a claim that has processed with an adverse determination. An adverse determination is a denial or penalty that unfavorably affects the member (such as increased liability). Requests are reviewed in conjunction with our medical policies and the member's benefit plan.

Provider reconsideration is a provider's written request for review of a prior benefit decision. This is a voluntary process we offer to ensure the benefit decision was correct. Common reasons that a provider may seek reconsideration of a claim include:

- If it is believed we did not apply coding and payment rules correctly.
- If there is disagreement with our interpretation of the member's plan of benefits, such as the definition of medical necessity.
- If there is disagreement with our denial of a claim with regard to provider versus member financial responsibilities.

Submitting Provider Reconsiderations
A provider can pursue provider reconsideration by using the Provider Reconsideration Form. This form is intended for use by physicians and other health care professionals in South Carolina only. Please be sure to complete the form in its entirety and attach all supporting documentation.

Provider reconsideration requests should include an explanation of the issue(s) to be reconsidered, such as seeking additional benefits, or why we should reconsider the service. We require you to include any supporting documentation, such as member's history and physical, any operative reports, office notes, pathology reports, hospital progress notes, radiology reports and/or laboratory reports. We are unable to review requests that are submitted without supporting documentation.

Send the Provider Reconsideration Form to the appropriate fax number or address as provided on the form.

The table includes some reasons you may or may not want to request provider reconsideration. Please note this is not a comprehensive list of reasons to submit a provider reconsideration form for claim denial.

Reasons You May Request Provider Reconsideration	**Reasons You May Not Request Provider Reconsideration**
Medical necessity determination	Deductible/coinsurance issues
Cosmetic services	Benefit limitations
Investigational/experimental services	Benefit exclusions
No authorization for inpatient stay	Membership issues
Multiple surgery and/or medical care a patient receives on the same day	Claims that include a primary insurer Explanation of Benefits (EOB)

If a provider is found to consistently file provider reconsideration requests for inappropriate reviews an education specialist may initiate a training session to discuss proper procedure.

Determinations
It generally takes BlueCross and BlueChoice® 30 days to complete provider reconsideration reviews. After the review is complete the appropriate service area will initiate claim adjustments or generate letters of denial to providers.

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