



**BlueCross BlueShield of Texas**

PO Box 833874  
Richardson, TX 75083-3874



**ACTIVECARE**

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TLC SURGICAL CENTER  
240 S LA CIENEGA BL #210  
BEVERLY HILLS CA 90211-3324

November 08, 2023

**This letter is a courtesy copy for your records.**



Have questions about this letter?  
Call a Personal Health Guide at 1-866-355-5999.



### Sandra Barrios, AN IMPORTANT UPDATE ON YOUR REQUEST THIS REQUEST WAS NOT APPROVED

Health information sent by your provider for the requested care was reviewed by a Medical Director who specializes in Obstetrics and Gynecology (OBG).  
The service requested has not been approved.

Non-Approved Service Procedure		Request ID	U23298AWDE
99244 / Consultation			
Effective Date	Expiration Date	Non-Approved Days / Units	
10/25/2023	01/23/2024	3	
Onset of Service / Admission Date:		10/25/2023	
Subscriber ID	837709775	Treatment Setting	Referral
Participant	Sandra Barrios	Physician	TLC SURGICAL CENTER
Date of Birth	11/09/1979	Facility/Provider	TLC SURGICAL CENTER
Admission Date	10/25/2023		



### WHY YOUR REQUEST WAS NOT APPROVED

Out of Network

#### From the Medical Director:

We received a request for in-network level of payment to a provider who is out of our network. After review, in-network level of coverage is denied for this out-of-network provider because this is excluded by your benefit contract. We have providers who manage your condition in your geographical area who are in our network. As a result, our network coverage is considered adequate, and the requested coverage can only be provided at out-of-network rates. This decision is based on "Schedule of Coverage" section found in the Benefits Booklet for TRS-ActiveCare HD and TRS-ActiveCare 2, effective September 1, 2023 August 31, 2024.

You can get copies of the rules, codes, and guidelines we used in making this decision free of charge by calling a Personal Health Guide at 1-866-355-5999.

Note for Provider: Service codes that do not require medical review are processed as approvals unless these services (codes) are ancillary to a primary service which has been denied or lacks contractual benefit.

## QUESTIONS? WE'RE HERE FOR YOU

For more information about your benefits, log in to your Blue Access for Members<sup>SM</sup> (BAM<sup>SM</sup>) account at [www.bcbstx.com/trsactivecare](http://www.bcbstx.com/trsactivecare).

Your doctor may call our Health Care Management department at 1-866-355-5999 to talk about your case with one of our physician reviewers.



### HOW TO APPEAL THE DECISION

You, your doctor or someone acting on your behalf can appeal this decision.

Three things to note:

- You have 180 days from receipt of this letter to file an appeal.
- If your health situation requires an urgent response, call a Personal Health Guide at 1-866-355-5999 to ask us to review your appeal right away.
- To learn more about our appeals process, see the Important Information enclosed.

Coverage, benefit and payment decisions are not treatment decisions. The decision to move forward with the proposed service/procedure remains between you and your doctor.

As always, feel free to call a Personal Health Guide at 1-866-355-5999.

Sincerely,

Blue Cross and Blue Shield of Texas  
Health Care Management Department

### ENCLOSURES

- ✓ Important Information - Appeal Information and Procedures
- ✓ Appeal Request Form
- ✓ Request for a Review by an Independent Review Organization (IRO)

A copy of this letter has been sent to:

Sandra Barrios  
8406 Intrepid Ln  
Rowlett, TX 75089-2647





### IMPORTANT INFORMATION (Retain for your records)

If we have denied your claim for benefits, in whole or in part, for a treatment or service, rescinded (see your Benefit Booklet for details) your coverage, or denied or limited your eligibility, this document serves as part of your notice of the denial decision.

#### Your Right to Appeal

You may appeal if you think you have been denied benefits in error. For all levels of appeals and reviews described below, you may give a written explanation of why you think we should change our decision and you may give any documents you want to add to make your point. For appeals, you may also make a verbal statement about your case. You will be notified if your plan requires any additional levels of appeal. You may also refer to your Benefit Booklet for more information on appeals.

Send a written appeal request to:      Appeal Coordinator  
Blue Cross and Blue Shield of Texas  
PO Box 660044  
Dallas, TX 75266-0044

To file an appeal or if you have questions, please call 800-521-2227 (TTY/TDD: 711), send a fax to 888-235-2936, or send a secure email using our Message Center by logging into Blue Access for Members<sup>SM</sup> (BAM<sup>SM</sup>) at bcbstx.com.

#### Authorized Representative

You can name a person to act for you (including an attorney) on your appeal or external review – known as an “authorized representative.” To use an authorized representative, you must first complete the necessary form. Call us at the number above to request the form, or to get more information if the person this document was sent to cannot act on his or her own. In urgent care situations, a doctor may act as your authorized representative without completing the form.

#### Standard Appeal

You, or an authorized representative (see above process for choosing someone to act for you), may appeal in writing or by phone. To send an appeal in writing use the contact information above and include any added information you want to give us as well as:

- A copy of the decision letter or Explanation of Benefits (EOB)
- The reference number or claim number (often found on the decision letter or EOB)

You can get copies free of charge of your relevant claim documents, including the rules, codes and guidelines we used in making a decision. To request the copies, use the contact information above. Unless your plan says otherwise, you have 180 calendar days from the date you received our initial decision to file your initial appeal.

#### What happens next?

We will send you a written decision for appeals that need medical review within 30 calendar days after we receive your appeal request, if you are appealing before getting a service. All other appeals will be answered within 60 calendar days.

#### Expedited (Urgent) Appeal

You, your authorized representative, or your doctor, can ask for an expedited appeal if you or your doctor believe that your life or health could be threatened by waiting for a standard appeal. To do so, you, your doctor, or your authorized representative, should call us at 800-521-2227 (TTY/TDD: 711) or fax your request to 918-551-2011. You have 180 calendar days to file your expedited appeal request. You may also ask for an Expedited External (Outside) Review, as described below, at the same time by calling 800-521-2227.

#### What happens next?

If you qualify for this type of appeal, we will give you a decision by phone within 72 hours after we receive your appeal request.



### Your Right to an External (Outside) Review

You may ask for an external review with an Independent Review Organization (IRO) if your appeal was denied based on any of the reasons below. You may also ask for external review if we failed to give you a timely decision as stated in the Standard Appeal section above, and your claim was denied for one of these reasons:

- A decision about the medical need for or the experimental or investigational status of a recommended treatment
- A condition was considered pre-existing
- Your health care coverage was rescinded (see your Benefit Booklet for details), or
- Your claim was denied and involves services protected, or you believe to be protected, under the No Surprises Act

If your case qualifies for external review, an IRO will review your case (including any data you'd like to add), at no cost to you, and make a final decision. To ask for an external review, you'll need to complete the necessary form and submit it to BCBSTX. You may get a form by calling the number on your ID card. Unless your plan says otherwise, you have 4 months from the date you received the decision notice to file your external review request.

#### What happens next?

If you qualify for an External Review, an IRO will review your case and mail you its decision within 45 calendar days. That decision is final and binding on BCBSTX and you, unless there are other state or federal rights available.

### Expedited (Urgent) External Review

You can ask for this type of review if:

- failure to get treatment in the time needed to complete an Expedited Appeal or an External Review would seriously harm your life, health or ability to regain maximum function;
- the request is about an admission, availability of care, continued stay or health care service that you received with emergency services, before your discharge from a facility;
- the request for treatment is experimental or investigational and your health care provider states in writing that the treatment would be much less effective if not promptly started; or,
- we failed to give you a decision within 72 hours of your request for an expedited appeal

The IRO that does the expedited external review will decide if the covered person needs to complete the expedited (urgent) appeal process before the Expedited (Urgent) External Review can be started. If you think your case may qualify for an Expedited External Review, call 800-521-2227.

#### What happens next?

If you qualify for this type of review, the IRO will give you a decision within 72 hours.

### Additional Rights

You may also have the right to bring an action under Section 502(a) of a law called ERISA. To learn more about your rights, this notice, or for assistance call the Employee Benefits Security Administration at 866-444-EBSA (3272).



**Health care coverage is important for everyone.**

We provide free communication aids and services for anyone with a disability or who needs language assistance. We do not discriminate on the basis of race, color, national origin, sex, gender identity, age, sexual orientation, health status or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator  
300 E. Randolph St.  
35th Floor  
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)  
TTY/TDD: 855-661-6965  
Fax: 855-661-6960

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services  
200 Independence Avenue SW  
Room 509F, HHH Building 1019  
Washington, DC 20201

Phone: 800-368-1019  
TTY/TDD: 800-537-7697  
Complaint Portal: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>  
Complaint Forms: <http://www.hhs.gov/ocr/office/file/index.html>



If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984.

Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984.
العربية Arabic	إن كان لديك أو لدى شخص تساعد أسئلة، فلهذا الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984.
繁體中文 Chinese	如果您，或您正在協助的對象，對此有疑問，您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員，請撥電話 號碼 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બાજુ વ્યક્તિને એસ.બી.એમ. કાયદાક્રમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કોલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसको सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में नि:शुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 855-710-6984 पर कॉल करें।
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
Diné Navajo	T'áá ní, éí doodago ła'da bíká anánílwo'ígíí, na'ídiłkidgo, ts'ídá bee ná ahóót'i' t'áá níí'k'e níká a'doolwoł dóó bína'ídiłkidígíí bee níí h odoonih. Ata'dahalne'ígíí bich'í' hodíílnih kwe'é 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سوالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با شماره 855-710-6984 تماس حاصل نمایید.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiegokolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulongan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کر رہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984.



**INTERNAL APPEAL REQUEST FORM**

**Patient Information**

Patient Name: \_\_\_\_\_

Member Identification Number: \_\_\_\_\_

Group Name and Number: \_\_\_\_\_

**Case Information**

Date(s) of Service (Service from Date and Service to Date): \_\_\_\_\_ - \_\_\_\_\_

Place of Service (Facility Name): \_\_\_\_\_

Request ID (if applicable): \_\_\_\_\_

Date Service/Procedure(s) non-allowed (Service Actual End Date): \_\_\_\_\_

**Physician/Facility/Provider Information**

Physician Name (Attending Provider Full Name): \_\_\_\_\_

Facility or Provider Name: \_\_\_\_\_

**Appellant Information**

Name of person submitting appeal: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Reason for Request: \_\_\_\_\_

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\_\_\_\_\_

An appeal may be submitted in writing, online or by phone. The return of this form is not required to request an appeal.

- To request an appeal by phone, call the toll-free phone number below
- To send a secure email using our Message Center, log into Blue Access for Members<sup>SM</sup> (BAM<sup>SM</sup>) at [bcbstx.com](http://bcbstx.com)
- To request an appeal in writing, attach additional information, Explanation of Benefits, Notification Letter and/or medical records for the dates of service being appealed and submit this form to:

Appeal Coordinator  
Blue Cross and Blue Shield of Texas  
PO Box 660044  
Dallas, TX 75266-0044

Phone: 888-697-0683 (TTY/TDD: 711)  
Fax: 888-235-2936



**You may request external review, at no cost to you, for the following:**

- a. An adverse determination or denial that involves medical judgment including a decision that the requested health care services are experimental or investigational;
- b. A determination on whether you are entitled to reasonable alternative standard for a reward under a wellness program;
- c. A determination on whether your Plan is complying with the non-quantitative treatment limitations that require parity in the application of medical management techniques; and
- d. Rescission of your coverage



**You can call 888-697-0683 to request an expedited external review at the same time you request an expedited internal review.**

**Today's Date:** (Month / Day / Year) \_\_\_\_\_

## Patient's Information

<b>Name:</b>	<b>Name:</b>
<b>ID:</b>	<b>ID:</b>
<b>Address:</b>	<b>Address:</b>
<b>Phone Number:</b>	<b>Phone Number:</b>

Have you already received these health services? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, when were the services received? (Month / Day / Year) \_\_\_\_\_

What was the Claim Number? \_\_\_\_\_

**Please state the reason you believe the decision was not correct: \_\_\_\_\_**

TX-IRO-FED\_20180417

IL17697 20231114B02 J6B8



## Urgent Care Claims

If your health may be in serious jeopardy or, in your doctor's opinion you may have pain that cannot be controlled while you wait for the external review decision, you may ask for an expedited review by having your health care provider call us at 888-697-0683 or fax your request to 972-907-1868.

## Rescission of Coverage Claims

A rescission is the retroactive cancellation of your coverage.

Is this request for external review of a rescission? \_\_\_\_\_ Yes \_\_\_\_\_ No

We will notify you within 5 days of receiving your request, whether your request is eligible for external review or whether additional information is needed to make that determination.

If your request is eligible for external review, an Independent Review Organization will be randomly assigned. You will receive notice from the assigned IRO that will include information on where to send any additional documents. You will have 10 business days to submit additional documents to the IRO.

We will provide to the IRO, within 5 business days, all documents that were considered in our review.

The IRO will complete an expedited review within 72 hours after assignment and will complete a standard external review within 45 days after assignment. You will receive written notice of the decision from the IRO.

The decision is binding except to the extent there are other remedies available under applicable law. If the IRO overturns our decision, we will provide coverage and or payment for the claim subject to any member share for deductible, co-insurance and co-payments.

**Please sign and date the form:**

Signature: \_\_\_\_\_ Date: (Month / Day / Year) \_\_\_\_\_

Printed Name: \_\_\_\_\_

I am the: ☐ Covered Person ☐ Parent or Legal Guardian ☐ Authorized Representative ☐ Provider of Record

**Authorized representative:** You can represent yourself, or you may ask another person, to act as your authorized representative. You may revoke this authorization at any time.

I, \_\_\_\_\_, hereby authorize \_\_\_\_\_ to pursue my external review appeal on my behalf.

Date: (Month / Day / Year) \_\_\_\_\_

\_\_\_\_\_  
Signature of Covered Person or Legal Representative

**NOTE:** The covered person must sign this form, unless they have a legal guardian, personal representative, are incapacitated, or have otherwise delegated authority to complete this form.

**Please send any additional clinical information to support your request for external review along with this form to:**

BCBSTX - External review request  
PO Box 660044  
Dallas, TX 75266-0044

or

Fax: 972-907-1868