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20240201 042324 Env [3.985] 1 of 3



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3785 1 AB 0.547 13  
JAIME SCHWARTZ  
240 S LA CIENEGA BLVD STE 200  
BEVERLY HILLS CA 90211-3340

02/01/2024



## Your Request

Reference Number: UM55396439  
Place of Service: On Campus Outpatient  
Hospital  
Provider: JAIME SCHWARTZ  
More details found at the end of this letter.

## Confidential Health Plan Information for:

MARY BERNS

Date of Birth: 09/06/1958

**Important information about the network status of your provider and/or facility.  
This letter is only about the network status.**

\*042324030101\*

Reviewed for your plan by AUMSI UM Services, Inc.

Dear MARY BERNS,

Recently, you or your doctor asked us to review a request to use a provider not in your plan's network (out-of-network), but apply your in-network level of benefits. This request is not approved and we'd like to let you know why.

Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc. Independent licensee of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. AUMSI UM Services, Inc. is a separate company providing utilization review services on behalf of Anthem Blue Cross and Blue Shield.



**Find a good doctor and get your checkups, shots and tests.**  
This type of "preventive" care is often covered at no cost. Keeping up on this care can help you stay healthy - and even catch problems early when they're easier and less costly to treat. Check with your doctor for the right preventive services for you.

The request tells us you or your doctor asked for a referral to a plastic surgeon. This provider is not in network for your plan. Your plan covers services at a higher benefit level given by a provider outside the plan network if we do not have a provider in our network that has the same skills. Your plan network has providers with the same skills who are able to provide the requested service. For this reason, the referral request for the out-of-network provider listed below is denied. It may help you to know that we reviewed this request using the definition of Authorized Referral or Authorized Services in your benefit plan.

JAIME SCHWARTZ is not in your plan's network. Does that matter?

Yes! Your plan covers more of the bill if you stay in-network. If you choose to receive care from this provider, these services will be reimbursed at your out-of-network level of benefits. Also, out-of-network providers can charge more. They may bill you for the difference between the total amount we allow to be paid and the amount they charge for a service. When you're charged this difference, it's called "balance billing". You can find other in-network providers at [www.anthem.com](http://www.anthem.com) or call us at the member service number on your ID card and we can help you.

### **You Should Know**

It might help you better understand how your plan works if you know how the decision was made.

This review was completed by clinical reviewer. They consider many things when making a decision:

- Your health status
- Network Provider Accessibility
- Your health plan

Please refer to the definition and exclusion sections of your plan benefits for information on Out of Network providers.

You, your provider or your authorized representative can get a free copy of the out of network benefit information used in making our decision by calling the number on your ID card.

### **What's Next**

- This doesn't mean that you can't or shouldn't receive this service. Only you and your doctor can decide what's best for you. If you have any questions about your benefits, you can call the Member Service number on your ID card.
- You can appeal this decision if you or your provider disagrees with it. We're including appeal information with this letter.
- We've told your provider about this decision. If they'd like to provide more information about your case, they can call our clinical reviewer at the number on your member ID card.

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Sincerely,

Care Management

**Enclosure:** Your Appeal or Grievance Rights.

**Note:** We're also sending a copy of this letter to JAIME SCHWARTZ.

**Attention Providers**

- If you'd like to request a peer to peer review and discuss our decision with our clinical reviewer, please contact us at the number on your member ID card before all related appeals have been completed. Please provide the following:
  - o Patient's name
  - o Reference #
  - o Procedure or service
  - o Date of service
- You may also receive a re-review of this service if you have additional information that might support its medical necessity. Please submit the information within 10 business days of the date of this letter. This re-review doesn't delay or replace other appeal rights that may be available.

One peer-to-peer review discussion and one re-review are available.

- You are required to return, destroy or further protect any PHI received on this document pertaining to members that you are not currently treating. Providers are required to immediately destroy any such PHI or safeguard the PHI for as long as it is retained. In no event are you permitted to use or re-disclose such PHI.

\*042324030200\*

**Your Health Care Team**

<b>Member</b>	MARY BERNS	<b>Date of Birth</b>	09/06/1958
<b>Provider</b>	JAIME SCHWARTZ	<b>Status</b>	Out-of-network
<b>Facility</b>	N/A	<b>Status</b>	N/A

You can learn more about services shown here, including diagnosis and treatment codes and what they mean. Just call the customer service number on your ID card.

### Request Details

Service	Start Date	End Date	Quantity	Code	Description
Consultation	02/01/2024	04/30/2024	1 Unit(s)	CPT 99244	OFFICE/OP CONSLTJ NEW/EST PT MOD MDM 40 MINUTES

## Rights Available to Members

If you do not agree with our adverse decision, you have the right to request an appeal. Unless your description of benefits states otherwise, you must request an appeal within 180 calendar days from the date you were notified of our adverse decision. Your provider, or any other person you choose, may appeal on your behalf. They may also help you during the appeal process. If you ask someone to represent or help you, please give them a signed authorization to include with the appeal.

### How do I request an expedited appeal?

If you have not had services (pre-service), or if you are now receiving services (concurrent), an appeal may be handled in an expedited manner if you, or your provider, believe that the condition could seriously jeopardize your life, health, or ability to regain maximum function or would subject you to severe pain that cannot be adequately managed without care or treatment by waiting for the appeal to be resolved using standard appeal time frames. To request an expedited appeal, you, your provider or your representative can contact customer service at the telephone number on your health plan identification card or send a written request to the following address: Grievances and Appeals, P.O. Box 105568, Atlanta, GA 30348-5568. Unless your description of benefits states otherwise, we will respond to expedited appeal requests within 72 hours.

If you are a member of a self-funded non-grandfathered health plan, as defined by the Patient Protection and Affordable Care Act (PPACA), you may request an expedited external review instead of, or at the same time as, exercising the expedited appeal process with your plan. To request an expedited external review, you, your provider or your representative can call customer service at the telephone number on your health plan identification card. If you prefer, you may send your written request, and any additional supporting documentation, to the following address: Grievances and Appeals, P.O. Box 105568, Atlanta, GA 30348-5568.

### How do I request a standard appeal?

To request a pre-service appeal, or to request an appeal for services you have already had (post-service), send a written request to the following address: Grievances and Appeals, P.O. Box 105568, Atlanta, GA 30348-5568. We encourage you to request appeals in writing. However, unless your description of benefits states otherwise, you may submit your appeal verbally by contacting customer service at the telephone number on your health plan identification card. Unless your description of benefits states otherwise, appeals of adverse decisions are resolved and a written response will be sent to you within 30 calendar days from the date we receive your appeal request.

### What should my appeal include?

You may include, if available, the following information with your appeal: the member's name and identification number; the name of the provider or facility who will or has provided care; date(s) of service; the claim or reference number for the specific decision with which you do not agree; and the specific reason(s) why you do not agree with the decision. You have the right, and we encourage you, to submit written comments, documents or other relevant information with your appeal.

### **How will my appeal be handled?**

The appropriate administrative and/or clinical specialists will review your appeal. All relevant information submitted by you or on your behalf will be reviewed regardless of whether it was considered at the time the initial decision was made. We may contact any providers who may have additional information to support your appeal. The reviewers will not have been involved in the initial decision. They also will not be a subordinate of the person who made the initial decision.

### **If I disagree with the decision on my appeal, what other rights do I have?**

If we deny your appeal, you will be provided with other dispute resolution options as applicable. If you are a member of a self-funded non-grandfathered health plan, as defined by PPACA, you may have the right to request an independent external review of our decision. Please refer to your description of benefits or contact customer service at the telephone number on your health plan identification card for detailed information regarding the entire appeal process.

### **ERISA Plan Members**

If your health benefit plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), once you have exhausted all mandatory appeal rights, you have the right to bring a civil action in federal court under section 502(a)(1)(B) of ERISA within one year, unless your plan provides for a longer period. Check your benefits booklet or plan documents to see if you have more time.

**RGA-CRAS (01/2019)**