BlueCross BlueShield of Illinois

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

300 East Randolph Street
Chicago, IL 60601

October 04, 2023

[redacted]

Subscriber:	[redacted]
Group/Sub. No.:	
Claim No.:	N/A
Appeal ID No.:	[redacted]
Appeal Type:	Member
Phone:	(800)458-6024
Fax:	(918)551-2011
Email:	Appeals@bcbsil.com

Subject: Your Appeal Results

Dear [redacted]:

We received your appeal on September 26, 2023, for the denial of the below treatment or service(s) for the below mentioned member. A Physician Reviewer who had no involvement in the original denial reviewed your request and the related medical records. The Physician Reviewer's qualifications along with supporting documentation of this appeal decision are listed below.

Appeal Decision	After careful review of the information we have, the appeal request has been **approved**.	
Physician Reviewer Information	Physician Reviewer Qualifications	M.D.
	Physician Reviewer Specialty	Psychiatry
	Physician Reviewer Credentials	Board Certified
	Physician Reviewer Sub Specialties	N/A
	Physician Reviewer Added Expertise	N/A

Service(s)	Mental Health Residential Treatment		
Member	[redacted]	Provider	Stephanie Hall, M.D.
Service Date(s)	September 21, 2022 - May 16, 2023	Facility	Village Behavioral Health, LLC
Initial Decision	Certification/approval is required from mental health advisor for the treatment of mental health or substance abuse conditions benefit	Initial Decision Code	754

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Appeal Type: Member

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	payment denied because mental health advisor was contacted but did not approve the treatment received.		
Initial Decision Date	September 23, 2023	Claim Amount	$0.00

You have 180 days from the initial decision date to file an appeal. If appeal is eligible for an Independent External Review (IER), you have 4 months from the date of this letter (with time allowed for mail delivery) to file an IER request.

Member Summary:

Per the medical necessity provision of your benefit plan, a medical necessity review has been completed. Based on the information provided, you did meet medical necessity guidelines for the following reasons: You had unsafe actions. You were a risk to self and others. You were struggling. You had a change in your family situation. You needed the support and structure of this treatment.

Criteria Referenced: MCG care guidelines Residential Behavioral Health Level of Care (Child/Adolescent) 25th Edition

Last Covered Day: 5/16/2023.

Procedure(s) Reviewed:

Mental Health Residential Treatment

This decision is based on:

MCG 25th Edition: November 13, 2021 - October 7, 2022 Residential Behavioral Health Level of Care (Child/Adolescent) 25th Edition

Additional information can be found in the members [redacted] Summary Plan Description and/or benefit booklet:

See "Definition Section" portion of your Benefit Booklet

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"Medically Necessary.....means that a specific medical, health care, supply or Hospital service is required for the treatment or management of a medical symptom or condition, and that the service, supply or care provided is the most efficient and economical service which can safely be provided.

The fact that your Physician may prescribe, order, recommend, approve or view hospitalization or other health care services and supplies as Medically Necessary, does not make the hospitalization, services or supplies Medically Necessary and does not mean that the Claim Administrator will pay the cost of the hospitalization, services or supplies. Please refer to the Exclusions – What Is Not Covered section of this booklet for additional information.

The Claim Administrator will make the initial decision whether hospitalization or other health care services or supplies were not Medically Necessary. In most instances this initial decision is made by the Claim administrator after you have been hospitalized or have received other health care services or supplies and after a claim for payment has been submitted. In making decisions of whether the hospitalization or other health care service(s) or supply(ies) are not Medically Necessary, and therefore not eligible for payment under the terms of this Plan, the Claim Administrator will take into account the information submitted to the Claim Administrator by your Provider(s), including any consultations with such Providers(s).

Hospitalization or other health care is not Medically Necessary when, applying the definition of Medical Necessary to the circumstances surrounding the hospitalization or other health care, it is determined that the medical services provided did not require an acute Hospital Inpatient (overnight) setting, but could have been provided in a Physician's office, the Outpatient department of a Hospital, or some other setting without adversely affecting the patient's condition."

N/A

The member's Summary Plan Description and/or benefit booklet states the levels of appeals available. Based on your plan, you had one internal appeal available to you. This was your one internal appeal. If this appeal has been denied, please see the attached "Request for a Review by an Independent Review Organization (IRO) Instructions" for the procedure to obtain IRO Review. This review is done at no cost to the member.

Additionally, the member or the authorized representative acting on behalf of the member may request, free of charge, a copy of any benefit provision, guideline, protocol, or other similar criterion that we relied upon to make this determination. The member may also, upon request, obtain free copies of all documents relevant to the appeal including the specific treatment and diagnosis code(s) and any new or additional evidence (if applicable) not utilized during the prior reviews.

Our acceptance of a form naming an authorized representative is not an acceptance of assignment or waiver of any anti-assignment provisions of the member's Summary Plan Description and/or benefit booklet. Please refer to the anti-assignment provisions, if any, in the Summary Plan Description and/or benefit booklet for more information.

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Note that actual availability of benefits is subject to the member's eligibility and other terms, conditions, limitations, provider eligibility, and exclusions of the member's health care benefit plan.

If you have questions or to request copies, please contact Customer Service at (800)458-6024.

Sincerely,

Valencia
Appeal Analyst
Appeals Department

Cc: Village Behavioral Health, LLC
Stephanie Hall MD

Attachment:
IL05.G.FI