Notice of Appeals Procedures

In accordance with 27-18.9-7
of the Rhode Island Health and Safety Laws

Quality Control Unit
P.O. Box 82657
Lincoln, NE 68501-2657
877-897-4328
402-309-2579 (FAX)

Please read this notice carefully. This notice contains important information about how to file grievances and appeals with us.

I. Definitions

"Adverse Benefit Determination" means a determination by us to deny or partially deny a reimbursement for a covered health care service. Adverse benefit determinations include:

- "Administrative adverse benefit determinations", meaning any adverse benefit determination that does not require the use of medical judgment or clinical criteria such as a determination of eligibility, a determination that a benefit is not a covered benefit, a determination that an administrative requirement was not followed, or any rescission of coverage; and
- "Non-Administrative adverse benefit determinations" or "utilization review adverse benefit determinations", meaning any adverse benefit determination that requires or involves the use of medical judgment or clinical criteria to determine whether the service being reviewed is medically necessary and/or appropriate. This includes the denial of treatments determined to be experimental or investigational.

"Appeal" means a subsequent review of an adverse benefit determination upon request by a covered person, including, but not limited to, a provider, authorized in writing to act on behalf of the covered person to reconsider all or part of the original adverse benefit determination.

"Benefit Determination" means a decision to approve or deny a request to provide or make payment for a covered health care service or treatment.

"Covered Person" means the person covered under the health benefit plan.

II. Levels of Review

Voluntary Reconsideration: The attending provider can request a peer-to-peer communication regarding a prospective adverse benefit determination. If the prospective adverse benefit determination relates to a pre-treatment estimate for Emergency Care, a reviewer will respond as soon as it can be arranged that same day. If the prospective adverse determination relates to a pre-treatment estimate for non-Emergency care, the peer-to-peer discussion will be held within one business day. For adverse benefit determinations made on a retrospective basis, peer-to-peer communication may be initiated by the reviewer or attending provider, as described in the First Level Appeal section.

To arrange a peer to peer communication, the attending provider should call the number above and ask for Utilization Review.

The following levels of review will be available to a covered person or their authorized representative, including, but not limited to, a provider, authorized in writing to act on behalf of the covered person. An appeal may be filed at any time.

First Level Appeal Review - for written appeals.

Expedited Appeal Review - for appeals in situations where the time frame of the standard internal review would seriously jeopardize the life or health of a covered person or would jeopardize the covered person's ability to regain maximum function

External Review - Available only for Appeals of Non-Administrative Benefit Determinations.
Following the first level internal appeal review, the covered person has a right to request an external review for adverse determinations. A request must be made within 4 months after receipt of a first level review decision.

A. First Level Appeal Reviews

A written appeal concerning any matter may be submitted by a covered person or their authorized representative within 180 calendar days after receipt of the adverse benefit determination.

For appeals involving non-administrative adverse benefit determinations, we will notify you and/or your provider within 15 calendar days from the date of the request for reconsideration or appeal is received. You and/or your provider will have 45 calendar days to request an appeal of the reconsideration decision and/or to submit additional information.

For appeals involving administrative adverse benefit determinations, we will notify you and/or your provider no later than 30 calendar days after receipt of the request for pretreatment estimates, and 60 calendar days for post-service claims.

The person or persons reviewing the appeal will not be the same person or persons who made the initial determination denying the initial claim or handling the matter that is the subject of the appeal, or who conducted the first level review. When the appeal is resulting from a non-administrative adverse determination, the review will be handled by a licensed provider with the same licensure status as the ordering provider. Before a final review decision is rendered, the reviewer will discuss the decision with the ordering provider (or a designee of the ordering provider). If the ordering provider or designee is not reasonably available, the review decision may be made based on the information available to the reviewer. We will make no fewer than two documented attempts to contact the provider or designee, giving the provider sufficient time to respond after each attempt. A decision following the first level review will not be final until we have provided notice to the covered person that they have the right to inspect the file and add information as necessary.

B. Expedited Appeal Reviews

When a covered person is eligible for an expedited appeal review, we shall complete the review and communicate our decision to the covered person and provider within 72 hours after receipt of the

request for appeal. Benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review. We are required to continue coverage pending the outcome of an appeal.

C. External Review - Available for Appeals of Non-Administrative Adverse Benefit Determinations Only

In cases where the first level appeal review to reverse a non-administrative adverse benefit determination is unsuccessful, the covered person has a right to request an independent external review. The external review will be conducted by an unrelated and objective appeal agency approved by The Office of the Health Insurance Commissioner.

A written request for an external appeal must be filed to us within 4 months of receipt of notice that the first level appeal has been denied. A covered person requesting an external appeal may be charged no more than a one hundred dollar ($100.00) external fee, with an annual limit not to exceed three hundred dollars ($300.00). The external appeal fee, if charged, must be refunded to the covered person if the adverse benefit determination is reversed through external review. Within at least five (5) business days of the request for an external appeal, a notice must be received by the claimant that their request has been forwarded to the Independent Review Organization (IRO). The notice shall include a description of the process for the claimant to submit additional information to the IRO within five (5) business days of receipt of this notification.

An Independent Review Organization (IRO) must notify you or your authorized representative of its external appeal decision to uphold or overturn the review agency decision:

(i) No more than ten (10) calendar days from receipt of all information necessary to complete the external review and not greater than forty-five (45) calendar days after the receipt of the request for external review; and

(ii) In the event of an expedited external appeal by the IRO for urgent or emergent care, as expeditiously as possible and no more than seventy-two (72) hours after the receipt of the request for the external appeal by the IRO. Notwithstanding provisions in this section to the contrary, this notice may be made orally but must be followed by a written decision within forty-eight (48) hours after oral notice is given.

D. Written Decision

When a decision is issued from any level of review, the following information will be included in the written decision:

1. a statement of the reviewer's understanding of the appeal;
2. the decision stated in clear terms and the contract basis or medical rationale supporting the decision, a reference to the evidence or documentation used as a basis for the decision; and
3. following a first level review, a description of the process to request an independent external review.

E. Request for Information

You may request copies of any non-privileged information related to your appeal and we will provide it at no charge. You may request the names of any experts we may have consulted who provided advice to us about your claim. If you request any clinical rationale and/or specific clinical guidelines used in the benefit determinations, we will provide them at no charge. Any request for information may be sent to us at:

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You have the right to contact The Office of the Health Insurance Commissioner's consumer resource program RIREACH, who can offer direct assistance to consumers who require help filing an appeal or navigating the healthcare marketplace.

Rhode Island Insurance Resource, Education, and Assistance Consumer Helpline (RIREACH)
300 Jefferson Boulevard, Suite 300, Warwick, RI 02888
Call Toll Free: 1-855- 747-3224
www.rireach.org