# Complaints, Adverse Benefit Determinations and Appeals

### Questions and Complaints

For questions and complaints, please call the toll-free number found on your health plan ID card. If you would rather send your complaint to us in writing, the representative can provide you with the address.

If the representative cannot resolve the issue over the phone, he/she can help you prepare and submit a written complaint. We will notify you of our decision regarding your complaint within 30 days of receiving it.

### Rhode Island Consumer Assistance Program

Rhode Island's Office of the Health Insurance Commissioner provides assistance with questions, complaints and concerns through its consumer resource program RIREACH (Rhode Island Insurance Resource, Education, and Assistance Consumer Helpline). RIREACH provides direct assistance to consumers who need help understanding and accessing their health coverage and is available to assist you at 1-855-747-3224 or www.RIREACH.org.

### Adverse Benefit Determinations

An adverse benefit determination is a decision made by us, in accordance with the terms of the Policy, to deny, reduce, terminate, or not pay for (in whole or in part) a benefit. Adverse benefit determinations include those based on your or your dependent's eligibility for coverage (for example, a rescission of coverage) as well those based on Utilization Review.

Utilization Review means the review of the medical necessity and/or appropriateness of a health care service. This includes those services determined to be experimental or investigational and decisions not to authorize medications either on or outside of our Prescription Drug List ("PDL").

### Appeals

- **Post-service Claims:** Post-service claims are those claims that are filed for payment of Benefits after medical care has been received.
- **Post-service Requests for Benefits:** Post-service requests for Benefits are requests for Benefits made after medical care has been received.
- **Pre-service Requests for Benefits:** Pre-service requests for Benefits are those requests that require prior authorization or benefit confirmation prior to receiving medical care.

### How to Request an Appeal

If you disagree with an adverse benefit determination made on a post-service claim, post-service request for Benefits, pre-service request for Benefits, concurrent request for Benefits, or rescission of coverage, you, your authorized representative, or your provider, can contact us in writing to formally request an appeal.

Your request for an appeal should include:

- ✓ The patient's name and the identification number from the ID card.
- ✓ The date(s) of medical service(s).
- ✓ The provider's name.
- ✓ The reason you believe the claim should be paid.
- ✓ Any documentation or other written information to support your request.

Your first appeal request must be submitted to us within 180 days after you receive the denial of a preservice request for Benefits or the claim denial. Information about this process will be included in the final determination letter sent from us. You may also follow this process to appeal an adverse benefit determination based on rescission of coverage.

**Appeals Process**

A qualified individual who was not involved in the initial decision being appealed will be chosen to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with expertise in the field, who was not involved in the prior determination. We may consult with, or ask medical experts to take part in the appeal process. You consent to this referral and the sharing of needed medical claim information. We will not make an adverse benefit determination until an appropriately qualified licensed practitioner has spoken with, or attempted to speak with, your attending or ordering physician. We will make no less than the minimum number of documented attempts required by state law to reach your attending physician before reaching a determination. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information related to your claim for Benefits, including copies of any internal rule, guideline or protocol that we may rely on in reaching a determination If any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and in advance of the due date of the response to the adverse benefit determination.

If you are appealing an adverse benefit determination of a concurrent request for Benefits, coverage will be continued without financial liability beyond the applicable cost share until you are notified of the appeal determination.

**Appeals Determinations**

You will be provided written or electronic notification of the decision on your appeal as follows:

- **Pre-service, concurrent or post-service requests, or post-service claims – clinical matters:** A first level appeal review will be conducted. You will be notified of the first level appeal decision within 15 days from receipt of a request with all of the necessary information.
- **Post-service claims - non-clinical matters:** A first level appeal review will be conducted. You will be notified of the first level appeal decision within 30 days from receipt of a request with all of the necessary information.

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure or service rendered.

You may have the right to external review through an Independent Review Organization (IRO) upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in our decision letter to you.

**Urgent Appeals that Require Immediate Action**

Your appeal may require urgent action if a delay in treatment could increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- We will provide you with a written or electronic determination within 2 business days or 72 hours, whichever is earlier, following receipt of your request with all of the necessary information for review of the appeal, taking into account the seriousness of your condition. If your urgent appeal involves an excluded drug, we will provide you with a written or electronic determination within 24 hours.
- If we need more information from your Physician to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

**External Review**

After you complete the internal appeal process, if you remain dissatisfied with our final appeal determination, you may request an external review through an outside Independent Review Organization (IRO). There is no minimum dollar amount that a claim must be in order to file an external appeal.

The external appeal is voluntary. An external review is comprised of all of the following:

- A preliminary review by us of the request.
- A referral of the request by us to the IRO.
- A decision by the IRO.

To request an external review, you must submit your request in writing to us within four (4) months of your receipt of our second level appeal review determination. A request for an external review of an urgent appeal may be made verbally. We will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the Policy at the time the health care service or procedure that is at issue in the request was provided.
- Has exhausted the applicable internal appeals process.
- Has provided all the information and forms required so that we may process the request.

After we complete the preliminary review, if your request is eligible for external review, we will forward your request to the IRO within five (5) business days for non-urgent appeals, or two (2) business days for an urgent appeal. We will provide to the assigned IRO the documents and information considered in making our determination. The documents include:

- All relevant medical records.
- All other documents relied upon by us.
- All other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request and we will include it with the documents forwarded to the IRO.

The IRO will notify you of its determination within ten (10) days for non-urgent appeals, or two (2) days for urgent appeals, after it receives this information. The determination of the IRO is binding upon us.

You may contact us at the toll-free number on your ID card for more information regarding external review rights.