



State Health Benefits Program Appeals Process

What Should I Do If I Have A Claim Denied Or Experience A Problem That I Am Unable to Resolve With My Health Plan?

The State Health Benefits Program has a specific appeals procedure for employees in the self-funded plans (COVA Care, COVA Connect, COVA HDHP [High Deductible Health Plan], Advantage 65, Advantage 65 with Dental/Vision, Option I, Option II) who experience final, adverse decisions from their health plan. For example, if an employee's medical claim is denied, the employee may appeal the denial to his or her health plan. If the plan issues an unfavorable final decision, then the employee may appeal to the Director of the Department of Human Resource Management (DHRM).

What Is The Process For Filing an Appeal?

For State Plan Members:

You must exhaust all appeals through your health plan before appealing to the Director of DHRM, and you must file the appeal in writing within 60 days of the final, adverse decision by your health plan. Appeals on non-claim matters, such as eligibility or policy, go to the Director of DHRM. Note that the following cannot be appealed to DHRM:

- *Specific coverage exclusions listed under "What is not covered" in the member handbook. However, denials of claims or coverage for services involving medical necessity (e.g. experimental/investigational procedures) can be appealed.*
- *Matters in which the sole issue is disagreement with policies, rules, regulations, contract or law.*
- *Claim amounts or service denials when the member's cost is less than \$300.*
- *Claim amounts above the allowable charge billed by a non-participating provider.*

In the above cases, the decision of the Plan is final. See member handbook for additional appeal information.

In the appeals process, the Director of DHRM will offer an informal fact-finding consultation. A decision will be rendered within 90 days of the submission of final information pertaining to the appeal. If the claim remains denied, specific written reasons will be given, including specific references to law, regulation, contract provisions or relevant policies which formed the basis for the denial. Also, at this level, the employee will be notified that, if desired, he or she may exercise the appeals process under the Administrative Process Act (APA).

For Regional Plan Members:

If you are enrolled in the Kaiser Permanente regional plan, you may appeal claims decisions to the State Corporation Commission (SCC) after you have exhausted internal appeals with the health plan. For more information, you may call (804) 371-9032 in Richmond or toll-free at (877) 310-6560, or access the SCC website at www.state.va.us/scc. Only appeals on eligibility or policy may be sent to the Director of DHRM.

What Is An External Review?

External review of denied claims is a review by independent clinicians. It works like this:

State Plans:

When your medical claim appeal is submitted to DHRM, the denial of coverage will also be reviewed by an impartial external review organization. It will be the responsibility of the external review organization to confidentially examine the final denial of claims to determine whether the decision of the plan is objective, clinically valid and compatible with established principles of health care.

Once the external review organization has made a decision, it must provide written notification to DHRM. The outcome of the independent review may be either to overturn or uphold the denial.

Kaiser Permanente HMO Regional Health Plan:

Once internal medical plan appeals are exhausted, members of the Kaiser Permanente regional plan may file a request with the State Corporation Commission's Bureau of Insurance for an external review of the denied services. All appeals must be filed within 30 days of the final decision of the insurance plan to deny coverage.

If the appeal meets the criteria, an independent health care review organization, not affiliated with the member's health plan, will be asked to conduct a review of the appeal.

A written recommendation will be made to the Commissioner of Insurance, who will issue a written ruling. The ruling is binding, with no opportunity to appeal.

What Are The Steps In the Appeals Process For The State Plans?

- Be sure that you have exhausted all internal appeals under your health plan.
- If you are enrolled in a state plan (COVA Care, COVA Connect, COVA HDHP, Advantage 65, Advantage 65 with Dental/Vision, Option I, Option II), file an appeal in writing with the Director of DHRM within 60 days of the final, adverse decision by your health plan.
- File appeals regarding eligibility with DHRM within 60 days of an adverse decision.

- Submit the following:
 - your full name
 - your ID #
 - the date of service
 - the name of the provider for whose services payment was denied; and
 - the reason you think the claim should be paid.
- You may download an external appeals form at www.dhrm.virginia.gov or obtain a copy from your benefits administrator at your place of employment.
- You are responsible for providing DHRM with all information necessary to review the denial of your claim.
- For statewide plans, the Director of DHRM will offer an informal, fact-finding consultation as part of the appeals process.
- If the final health plan decision concerns a medical claim, the claim will be reviewed by both DHRM and an independent clinical review organization.
- The Director of DHRM will render a decision within 90 days of submission of final information pertaining to the claim denial.
- In accordance with HIPAA Privacy, for medical and mental health and substance abuse claims, you must submit a HIPAA Authorization Form to DHRM before your appeal can be processed. The form is available on the DHRM website at www.dhrm.virginia.gov/hbenefits/hipaa/hipaauthorization.pdf or may be requested from your Benefits Administrator.