COMMONWEALTH OF VIRGINIA
DEPARTMENT OF HUMAN RESOURCE MANAGEMENT
Office of Health Benefits

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 HealthAware, COVA HDHP [High Deductible Health Plan], Advantage 65 and Option II.

When a member of the State health plan receives a final, adverse decision from their health plan, they may appeal the denial to their plan administrator (internal appeal process). If the plan administrator issues an unfavorable final decision, then the member may appeal to the Director of the Department of Human Resource Management (DHRM) (external appeal process).

Appeals regarding adverse claim determinations made by your health plan administrator are reviewed by an independent review organization. When the appeal is regarding an administrative decision, such as eligibility or non-claim related issues, the case is reviewed by DHRM.

DHRM does not accept appeals for matters in which the sole issue is a disagreement with policies, rules, regulations, contract or law.

What Is The Process For Filing an Appeal?

Self-Funded State Health Plans

Before filing a health care appeal to the Director of DHRM, you must exhaust all health care appeals through your plan administrator. You must submit your appeal request in writing within four (4) months of the final adverse decision by your plan administrator. You may only appeal adverse benefit determinations by the plan administrator that are based on your Health Plan's requirements for medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, or the failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational.

In some circumstances, you have the right to an expedited appeal. An expedited appeal means the independent review organization will render a decision in a shorter timeframe. However, in order to request an expedited appeal you must meet the criteria listed in the health plan's Member Handbook.

When your health plan appeal is submitted to the Director of DHRM, the denial of coverage will be reviewed by an independent review organization. If the appeal is not expedited, you will receive an "Appeal Notice" informing you to submit additional supporting documentation to the independent

review organization within five (5) business days of receiving the notice. It will be the responsibility of the independent 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 independent review organization has made a decision, it must provide written notification to you, DHRM, and the plan administrator. The outcome of the independent review may be either to overturn or uphold the denial. If the independent review organizations decision is not in your favor, you have the right to exercise the appeals process under the Administrative Process Act (APA).

Administrative Appeals:

If your appeal is regarding a non-claim related issue, the Director of DHRM may offer an informal fact-finding consultation. A written decision will be rendered. If the decision is not in your favor, specific reasons will be provided including law, regulations, contract provisions or policies. If desired, you will have the right to further appeal through the Administrative Process Act (APA).

Non-Self-Funded State Health Plans:

If you are enrolled in the Kaiser Permanente HMO, Optima Health Vantage HMO or TRICARE Supplement 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 administrative appeals for members enrolled in these plans may be sent to the Director of DHRM.

What Are The Steps In the DHRM Appeals Process?

- Be sure that you have exhausted all internal appeals under your health plan.
- Submit your appeal in writing to the Director of DHRM within four (4) months of the final adverse decision.
- You may download an external appeal form at www.dhrm.virginia.gov or obtain a copy from your benefits administrator at your place of employment.
- You must submit the completed HIPAA Authorization Form before your appeal can be processed.
- You are responsible for providing DHRM with all information necessary to review your appeal.
- If the final adverse determination by the health plan concerns a health care claim, the claim will be reviewed by an independent review organization who will render the decision.
- If the concern is pertaining to an administrative decision, the Director of DHRM may offer an informal, fact-finding consultation (IFFC) as part of the appeals process. The Director will review the information presented and render the decision.