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. These plans are COVA Care, COVA HealthAware, COVA HDHP [High Deductible Health Plan], Advantage 65, Advantage 65 with Dental/Vision, 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 denied claims are reviewed by an independent review organization.

Other appeal, are appeals regarding decisions made by DHRM such as eligibility for a benefits program. In these cases, the appeals are reviewed by DHRM.

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. Note that 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 plan's Member Handbook, as follows:

- The adverse decision involves a medical condition for which the time frame for completing an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, and You or your authorized representative has requested an expedited internal appeal from the Plan Administrator;
- The adverse decision involves a medical condition for which the time frame for completing a standard external appeal would seriously jeopardize your life or health

or would jeopardize your ability to regain maximum function, or if the final adverse decision concerns an admission, availability of care, continued stay, or health care service for which You received emergency services, but have not been discharged from a facility; or

- The adverse decision involves prescriptions to alleviate cancer pain.

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 5 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 organization upheld or partially upheld the plan administrator's denial, the member will be notified that, if desired, he or she may exercise the appeals process under the Administrative Process Act (APA).

For Eligibility Appeals :

If your appeal is regarding eligibility, the Director of DHRM may offer an informal fact-finding consultation. A decision will be rendered. If the claim is 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, the employee will be notified that, if desired, he or she may exercise the appeals process under the Administrative Process Act (APA).

For Non-Self Funded State Health Plans:

If you are enrolled in the Kaiser Permanente or Optima Health regional plan, 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.scc.virginia.gov. Only appeals involving eligibility or policy may be sent to the Director ~~of DHR~~M.

What Are The Steps in the DHRM Appeals Process?

- Be sure that you have exhausted all internal appeals under your health plan.
- If you are enrolled in a state plan (COVA Care, COVA HealthAware, COVA HDHP, Advantage 65, Advantage 65 with Dental/Vision, Option II), file an appeal in writing with the Director of DHRM within four (4) of the final adverse decision by your health plan.
- File appeals regarding eligibility with DHRM within four (4) months of an adverse decision.
- Submit the following:

- Your full name

- Your identification number
- Your address
- Your telephone number
- The date(s) of the medical service
- Your specific medical condition(s) or symptom(s)
- Your provider's name
- The service or supply for which approval of benefits is being sought, and
- Any reasons why the appeal should be processed on an expedited basis.

➢ 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 eligibility appeals of 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 health care claim, the claim will be reviewed by an independent clinical review organization.

➢ The Director of DHRM will render a decision pertaining to the eligibility 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.