Notice of Appeals Procedures

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

Quality Control Unit
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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.

"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

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.

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 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. 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. 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.

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