

**MEDICAL ASSOCIATES HEALTH PLANS
HEALTH CHOICE POLICY AND PROCEDURE MANUAL
POLICY NUMBER: PP 15
PAGE: 1**

POLICY TITLE: HEALTH CHOICES APPEAL POLICY

POLICY STATEMENT: When the Health Choice Staff makes a non-certification for a medical service the following denial procedure will be implemented.

Health Choices Appeal Process

Is the Appeal received within 60 days of the original denial?		
YES	NO	
Gather all pertinent information to review the claim. Depending on the situation should be reviewed by the Health Choices Case Manager with input from the Medical Director or the Claims processor with input from the Claims Manager.	Send letter explaining that the time limitation to appeal under the Plan Document has expired. Sample letter timeout attached.	
Overturning Original Decision?		
YES	NO	
Write employee a letter explaining that based on the additional information submitted we are able to overturn our decision, also indicate that authorization for the procedure has been granted or the denied claims will be reprocessed. This letter should come from the Case Manager if an authorization issue or the Claims Manager if a benefits issue. Sample letter overturn attached.	We review requests, including any additional information, make recommendations to uphold original determination, including reason why and if additional clinical information submitted, why it does not change the decision, draft response, forward original decision information and any additional submitted information to the Benefit Coordinator, who will contact the Plan Administrator and discuss the situation. The Plan Administrator may uphold or reverse our decision.	

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POLICY NUMBER: PP 15
PAGE: 3**

ISSUES – DENIALS - APPEALS

Preservice non urgent _____ (15 days)
Urgent Preservice _____ (72 hours)
Urgent Concurrent Review _____ (24 hours)
Post Service _____ (30 days)
Extension requested Yes ___ No ___
Member Notified of need for extension _____

Auth # _____ Member Name _____
Member # _____ Contract _____ State _____
Case Manager _____ Plan Type: (HC, HMO, POS, Medicare)
Date Request Received _____ Phone # of Dr. Office _____

Summary of question/issue:

CMO decision:

Signature _____ Date _____



**MEDICAL ASSOCIATES HEALTH PLANS
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POLICY NUMBER: PP 15
PAGE: 4**

**NICC and City of Dubuque
S W Schools follow WI rules**

APPEAL UPHELD LETTER

Date

Name Health Plan: (Employer's Name)
Address Group: (Group Number)
City, State, Zip Employee:
Patient:

Dear Subscriber:

On (date) an appeal was received by Health Choices from (Name of physician) for (Procedure). This letter is to notify you that coverage has not been approved and our original decision remains.

According to the (Employer name) Plan Document, Page (), Section (), Medically necessity is defined as:

(Definition of medical necessity from the Plan Document and/or any relevant information concerning rationale for denial.)

If you continue to feel that this decision is not consistent with your benefits as outlined in the Medical Plan Document, you have the right to request an external review from the Iowa Insurance Division.

In order to request an external review you or your physician must send a written request within 60 (sixty) days of the date of this letter to: Division of Insurance, 330 Maple Street, Des Moines, IA 50319. A copy of the denial from Health choices and a check or money order in the amount of \$25.00 made payable to the Iowa Insurance Division. (The \$25 fee may be waived upon request. If a waiver of the filing fee is being requested, an explanation of why the member is requesting such waiver should be included.)

If you have any questions on this procedure, please call Health Care Services at (563) 5/84-3275 or 1-800-325-7442.

Sincerely,

Name
Title

CC: (physician)

**MEDICAL ASSOCIATES HEALTH PLANS
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POLICY NUMBER: PP 15
PAGE: 5**

**HC Appeal Time
Limitation Expired**

Date

Name

Address

City, State, Zip

Re:

Dear Name:

Health Choices has received and reviewed your request for appeal dated (date).

Under the terms of the (name of group) Plan Document and your right under ERISA, you have 60 days from the date of the denial to submit your appeal.

Our original decision was dated (date of decision), therefore more than 60 days have passed.

We are unable to consider your request based on the terms of your Plan Document.

Sincerely,

Name

Title

**MEDICAL ASSOCIATES HEALTH PLANS
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POLICY NUMBER: PP 15
PAGE: 6**

**HC Appeal
Overturn**

Date

Name

Address

City, State, Zip

Re:

Dear Name:

Health Choices has received and reviewed your request for appeal dated (date).

Based on the additional information submitted, we find that coverage for this service under the terms of the (name of group) Plan should be provided.

Authorization has been granted for this procedure.

If you have any further questions please contact us at (563) 548-3275 or 1-800-325-7442.

Sincerely,

Name

Title

**MEDICAL ASSOCIATES HEALTH PLANS
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POLICY NUMBER: PP 15
PAGE: 7**

HC PA Overturn

Date

Name
Address
City, State, Zip

Re:

Dear Name:

Health Choices has received and reviewed your request for appeal dated (date).

Based on the additional information submitted along with consideration from the Plan Administrator of the (name of group) Plan, we find that coverage for this service under the terms of the (name of group) Plan should be provided.

Authorization has been granted for this procedure.

If you have any further questions please contact us at (563)584-3275 or 1-800-325-7442.

Sincerely,

Name
Title