THE OHIO STATE UNIVERSITY
HEALTH PLAN

Subject: Member or Provider Appeals Process

Effective Date: 9/96
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PURPOSE

To provide a consistent process by which a health plan member, authorized representative, or provider may request and receive timely review of a wholly or partially denied claim related to medical necessity, appropriateness, or benefits rule.

Federal and state law requires group health plans to provide an internal and external review process.

POLICY

The OSU Health Plan (OSUHP) will ensure that covered persons and participating providers have the right to request an appeal, are knowledgeable of this right, and the procedure by which to initiate the process. All processes and procedures comply with federal and state law. Details describing these rights and responsibilities are available in the Ohio State University Faculty and Staff Health Plans Specific Plan Details Document (SPD) available online at https://hr.osu.edu/wp-content/uploads/medical-spd.pdf.

DEFINITIONS

Adverse Benefit Determination:
An "adverse benefit determination" means: (1) a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for, a benefit, including as a result of (a) a determination of eligibility to participate in the Plan; (b) the application of any utilization review; (c) a determination that a health care service or item does not meet the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, including experimental or investigational treatments; (d) a determination that a health care service is not a covered benefit; or (e) the imposition of an exclusion, including exclusions for pre-existing conditions, source of injury, network, or any other limitation on benefits that would otherwise be covered; and (2) a rescission of your coverage.

Authorized Representative:
An "authorized representative" means an individual who may act on behalf of the member with respect to a benefit claim or appeal under these procedures and who is any of the following: (1) a person to whom you have given express, written consent in the Appointment of Authorized Representative section of an Appeal Form to represent you in an internal appeals process or external review process of an adverse benefit determination; (2) a person authorized by law to provide substituted consent for you; or (3) a family member or a treating health care professional, but only when you are unable to provide consent.

Benefits Appeals Committee:
For appeals pertaining to enrollment (including eligibility to enroll and to make changes to enrollment), "Benefits Appeals Committee" means the Ohio State University Benefits Appeals Committee. For all other appeals, "Benefits Appeals Committee" means OSUHP's Benefits Appeals Committee. A subset

of OSUHP's Benefits Appeals Committee, the Internal Appeals Committee, reviews all clinical adverse benefit determinations.

Third Party Administrator:
"Third Party Administrator" means the University's third party administrator for medical claims processing, which is Trustmark Health Benefits.

TYPES OF CLAIMS
There are four categories of claims. Each category has a somewhat different claim determination and appeal rules. The primary difference is the period within which claims and appeals of an adverse benefit determination is determined.

Pre-Service: Any service, whole or part, which the OSUHP must approve in advance of the member obtaining care or services.

Concurrent Review: Any review for an extension of a previously approved ongoing course of treatment over a period of time or number of treatments. This typically is associated with inpatient care or ongoing outpatient services that require an authorization.

Post-Service: Any review for care or services that have already been received and are not an Urgent Care Claim, a pre-Service Claim or a Concurrent Care Claim. (i.e.: retrospective review).

Urgent Care: Any request for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the covered person's ability to regain maximum function or subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request. Any request for an urgent appeal requires a statement from the treating physician certifying in writing on the prescribed form that the medical condition meets the above definition.

PROCEDURE

I. APPEAL PROCESS

A. The policy and process for filing an appeal will be communicated to health plan members and providers. This notification will always be in written form and may be transmitted telephonically or electronically if so desired by appellant:
   1. Covered persons' rights/responsibilities of appeal will be written in the Medical Specific Plan Detail document.
   2. Participating providers' rights/responsibilities of appeal will be written in Provider Manual.
   3. EOB from third party administrator will provide explanation for denial of claim and advise health plan member and providers of right to appeal this decision.
   4. If a member or provider calls the third party administrator, the OSU Benefits Department or OSUHP regarding notification of a denied claim, the rights and responsibilities of appeal will be explained as appropriate.

B. The covered person, authorized representative or provider may submit a written request for reconsideration of a denied claim after notification of denial (from the third party administrator or OSUHP). All relevant information should be included with the written request on the prescribed form, which is included with the adverse benefit determination. Refer to the table below for applicable timeframes.

C. Once written notice has been received, the appeal will be reviewed and written notification will be made according to the time frames provided in the table below.

D. There are potentially four levels of the appeal process:
   1. Third Party Administrator:

a. **First Level Internal Appeal**: **Post-Service Claim**
For a denied Post-Service Claim, the TPA (Trustmark) will review the initial appeal.

2. OSU Health Plan Utilization Management:
   a. **Pre-Service, Concurrent, Urgent Claim [Without Appeal Form]**
   OSUHP Utilization Management staff will review reconsideration requests (i.e., additional information has been submitted on a previously denied claim, but a Second Level Appeal has not been requested with the appropriate appeal form(s).)
   b. **Second Level Internal Appeal: Post-Service Claim [Without Appeal Form]**
   If the provider, member or authorized representative contests a decision by the TPA to uphold a Post-Service Claim denial, they may request a Second Level Internal Appeal. OSUHP Utilization Management staff will review Second Level Appeals that do not include the Internal Appeal Form(s).
3. Benefits Appeals Committee/Internal Appeals Committee:
   a. **First Level Internal Appeal: Pre-Service, Concurrent, Urgent Claim [With Appeal Form]**
   Following an Adverse Benefit determination for a Pre-service, Concurrent or Urgent claim, the appellant can request a First Level Internal Appeal by submitting the appropriate form(s) to the OSUHP Benefits Appeals Committee.
   b. **Second Level Internal Appeal: Post-Service Claim [With Appeal Form]**
   If the provider, member or authorized representative contests a decision by the TPA to uphold a Post-Service Claim denial, they may request a Second Level Internal Appeal. The Appeals Coordinator will review Second Level Appeals that include the Internal Appeal Form(s) and the appeals will be presented to the Benefits Appeals Committee as applicable.
4. Ohio Department of Insurance / External Review Organization
   a. **External Appeal:**
   The appellant can contest any negative decision made by the OSUHP Benefits Appeals Committee and request a review by the Ohio Department of Insurance. The Department of Insurance shall make all final and binding decisions regarding administrative benefit rules. If the Department of Insurance deems that the question of medical necessity exists, the department will direct OSUHP to submit the appeal to a designated external review organization (ERO). All decisions made by the ERO are final and binding. Resolution of the appeal will be communicated in writing to the appellant within 30 days.

E. In certain instances, expeditious or immediate review may be required and should be resolved within 48 hours (except for external appeals):
   1. If legal action against the member or provider is an immediate threat.
   2. A physician certifies in writing on the prescribed form that the time periods that otherwise apply to a routine pre-service claim could seriously jeopardize the claimant's life or health or ability to regain maximum function or would – in the opinion of the physician with knowledge of the claimant's medical condition – subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.
F. All appeals activities are recorded electronically in the health management documentation system.

II. TIMEFRAMES

Type	Received by OSUHP	Response
	Pre-Service :	
Internal	Benefit Appeals Committee (BAC) 180 days from receipt of Initial Adverse Benefit Determination	10 days
External	Ohio Department of Insurance (ODI) 180 days from receipt of Final Adverse Benefit Determination	30 days
	Post-Service:	
1st Level Internal	Third Party Administrator 180 days from receipt of denied claim	30 days
2nd Level Internal	OSUHP/BAC 60 days from receipt of TPA's Adverse Benefit Determination	30 days
External	ODI 180 days from receipt of Final Adverse Benefit Determination	30 days
	Urgent:	
	Internal/ BAC 180 days from receipt of Adverse Benefit Determination	48 hours
	External /ODI 180 days from receipt of Adverse Benefit Determination	72 hours
	Concurrent:	
	Refer to Urgent, Pre-service or Post-service whichever is applicable	Varies

RESPONSIBILITIES/REPORTING

Utilization Management/Case Management staff, the Appeals Coordinator and the Medical Director are responsible for this process. Review of medical information may be delegated to specialty medical consultants as deemed necessary.

REFERENCES

39 Ohio Rev. Code. § 3922 (2011), available at http://codes.ohio.gov/orc/3922

Senate Bill Number 129, 131st General Assembly of the State of Ohio (2016).

US Department of Labor, Benefit Claims Procedure Regulation, https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/benefit-claims-procedure-regulation