Retired Public Employees of Alaska
Medical, Dental, Vision and Audio Appeal Instructions

APPEALING A CLAIM or Pre-certification DENIAL

WHY you should appeal

Filing an appeal has two purposes:

1) To correct any mistakes or misinterpretation of **your** claim so you are properly reimbursed based on our plan's provisions.

2) To help **preserve the retirement benefits of all retirees** by finding and correcting errors or misinterpretations of our plan.

Our right to benefits is created in the Alaska Constitution and confirmed in the Supreme Court decision *Duncan v. Retired Public Employees of Alaska*. That decision found that *"Any changes in the medical plans that operate to an employee's disadvantage must be offset by a comparable new advantage to that employee."* It also cited Article XII, §7 of the Constitution, which says in part *"Accrued benefits of these systems shall not be diminished or impaired."*

HOW to appeal

On January 1, 2014, the Division of Retirement and Benefits (DRB) substantially changed the appeal process for the retiree Medical, Dental/Vision/Audio (DVA), and Long Term Care (LTC) plans including writing themselves out of the appeal process.

The appeal information below is based on provisions in the 1/1/14 Amendment and information that RPEA received from DRB. As we receive updated information, we will revise the instructions below.

New Appeal Levels

The appeal process now has three levels instead of four. (DRB is no longer involved in hearing or deciding appeals.)

Appeal levels for the Medical plan and the Vision/Audio portion of the DVA plan are:

- Level I: Aetna for all issues
- Level II: Aetna for plan design or claim denial issues, or Independent Review Organization (IRO) for medical issues*
- Level III: Office of Administrative Hearings (OAH)**

Appeal levels for the dental plan are:

- Level I: Moda Health/Delta for all issues
- Level II: Moda Health/Delta for plan design or claim denial issues, or Independent Review Organization (IRO) for dental issues*
- Level III: Office of Administrative Hearings (OAH)**

*IROs are companies hired by Aetna or Moda/Delta Health to review independently appeals that require medical or dental expertise to determine *medical necessity*. Aetna and Moda/Delta

have each contracted with three IROs. Medical or dental-based appeals are randomly assigned to one of the three IROs .

**OAH is part of the Alaska Department of Administration. The office has a panel of administrative law judges who hear Level III appeals and independently determine the claim appeal based on Alaska law.

Remember **all appeals must be in writing** under the 1/1/14 Amendment.

Aetna may offer to take Level I appeals orally and put them in writing for you. *If you choose to file your appeal this way, we suggest you request within 24 hours a copy of what Aetna writes to be sure it is correct.* **Ultimately, you are responsible that your appeal is in writing and filed within the time limits in the 1/1/14 Amendment.** The State has instructed Aetna not to take oral Level I appeals, but some have reported that Aetna is still sometimes offering to do so.

URGENT APPEALS WHEN DELAY IS HARMFUL

If you have been denied a procedure or treatment and your medical provider determines that a delay could harm your health, you and your provider can contact Aetna Patient Care Management. Call 800-333-4432 to request an expedited appeal. Aetna should respond no later than 72 hours following receipt of your Level I or Level II request for an expedited appeal.

SUBMITTING APPEALS—MEDICAL, VISION/AUDIO and DENTAL:

Before you begin:

a. *The retiree plan currently consists of the 2003 Retiree Benefit Book, found at http://doa.alaska.gov/drb/pdf/ghlb/retiree/RetireeInsuranceBooklet2003with2016amendment.pdf the 1/1/2014 Amendment at http://doa.alaska.gov/drb/pdf/ghlb/retiree/retireePlanAmendment12312013.pdf - zoom=100 and the 2016b amendment: http://doa.alaska.gov/drb/pdf/ghlb/retiree/retireePlanAmendment01012016.pdf*

b. *Review these documents under the* retiree/plan booklets section *at* AlaskaCare.gov. *The 1/1/2014 Amendment describes the appeal process for more than one type of claim and may be confusing. The instructions below pertain to appeals initiated following: (1.) the receipt of an Explanation of Benefits (EOB) that denies payment for medical or DVA care that has been received, or (2.) the denial of a request for pre-certification.*

c. Check the Explanation of Benefits (EOB). Be sure you understand it. Read the front and back for the explanation of coded remarks.

d. Call *Aetna* at *855-784-8646* if you need further clarification. *Aetna may be willing to reprocess your claim in a timely manner. A request to reprocess a claim by you OR your provider is*

not *the same as an official Level I appeal.*

e. Contact your medical/dental provider to be sure the claim was coded correctly. Incorrectly coded claims may result in denials. This happens when a procedure is coded incorrectly and the incorrect code is not covered by our plan.

f. Log all telephone calls to Aetna, the Division of Retirement and Benefits, and medical providers. The log should include the date, time, representative's name and a summary of each conversation. If possible, speak to the same representative each time. *If you talk to a helpful representative, ask for that person's direct extension number*.

Level I Appeal for Medical, Vision/Audio

1. When you decide to appeal a denial, write your appeal letter. *The 2014 Plan Amendment specifies that* ***an appeal must be in writing and received within 180 days of the date the Explanation of Benefits (EOB) was written****.* Include only information relevant to the claim. **Be factual,** not emotional. A decision about your appeal will be based on the facts.

2. We recommend you use the following language RPEA developed as part of the cover page for your appeal:

I am appealing the denial of coverage for_____provided to me on_____, 20____.
The State of Alaska provides health benefits for individuals, including retirees, who are entitled to coverage under applicable statutes. These benefits are described in the Retiree Health Plan Booklet and include benefits under DVA for retirees who elect coverage. The benefits provided under this coverage cannot be diminished without an equal or greater offset of enhanced benefits.

- When I (or my spouse) retired in _____ (date of retirement) I was/we were entitled to receive medical coverage under the Retiree Health Plan. I was entitled to elect DVA coverage.
- The medical and DVA benefits provided under this coverage are described in the 2003 Retiree Insurance Information Booklet prior to the 2014 Amendments.
- I elected to pay for DVA coverage through monthly withholdings from my monthly retirement payment.
- I am entitled to receive the medical or DVA benefits and coverage as implemented under the Retiree Health Plan prior to the 2014 Amendments, which constituted an impermissible diminishment of benefits.
- PERS/TRS retirement benefits, including medical and DVA benefits, are vested, constitutionally protected rights that cannot be diminished without an equal or greater enhancement.
- DOA has unilaterally diminished benefits and coverage as described in the 2003 Retiree Benefits Booklet such as treatment for_____, and has not provided any enhanced benefits under the Retiree Health Plan to offset these diminished benefits

Attached are the details of my appeal and supporting documents.

You can copy this at: http://rpea.apea-aft.org/medical/benefit_issues/2016/Recommended-cover-page-language-for-Dental-appeals.pdf

3. Your letter should include:

    a. Your mailing address and phone number.
    b. Name of patient.
    c. Name of Retiree/Subscriber and ID number.
    d. Group Number.
    e. Claim Number.
    f. Date of Service or Date of Denial for Certification.
    g. Include in your letter:
        - What decision you are appealing,
        - Aetna's reason for denying your claim,
        - Why you disagree with its denial,
        - If you had this service or treatment and it was previously covered, note and document that.

4. Make copies of the Explanation of Benefits, correspondence, statements from providers and relevant medical records to send with your appeal letter. If you have had this procedure or service before and it was covered, include copies of EOBs showing that.

5. Mail your appeal letter as soon as possible after you receive the Explanation of Benefits to:

    Aetna
    ATTN: AlaskaCare Member Appeal Level I
    P.O. Box 14463
    Lexington, KY 40512-4463

6. **Always send the appeal and any other communications by priority or certified mail, return receipt requested. The receipt will prove that the appeal was received within the required time**. If you use Priority Mail, request both a signature and tracking. *Aetna does not have an office in Alaska where appeal may be submitted in person.*

7. *Aetna should send you a postcard advising you that your appeal has been received. They do not provide a time frame as to when the appeal was received nor when the appeal deadline to respond has been reached. However, they are required to respond no later than 30 days after receipt of a precertification appeal or 60 days after an appeal of a claim denial.* If you do not receive a timely response, *call Aetna at 855-784-8646.*

8. If Aetna does not send a written decision by those deadlines, treat that failure as a denial and proceed to Level II.

9. If you are not satisfied with Aetna's Level I response, you may file a Level II appeal. (See below.)

Level II Appeal for Medical, Vision/Audio

If your Level I appeal is not resolved to your satisfaction, or if Aetna fails to issue a timely written decision, the next step is to file a Level II appeal. *There are two deadlines for this level appeal*:

1. If you're appealing based on the plan or policy itself that ***appeal must be in writing and should be received by Aetna within 180 days*** of the date the Level I decision letter was issued (date on the letter).

2. **But, if you wish to file an *appeal based on medical judgment, that appeal must be received by Aetna within four months or 120 days of the date on your level I decision letter***.

3. As with the initial appeal, send the appeal and any other communications by priority or certified mail, return receipt requested. The receipt will prove that the appeal was received within the required time. If you use Priority Mail, request both a signature and tracking.

Mail your appeal to:

Aetna
ATTN: AlaskaCare Member Appeal Level II
P.O. Box 14463
Lexington, KY 40512-4463

Individuals who were not involved in the review of your Level I appeal will review your Level II appeal. **Aetna is required to respond to an appeal regarding precertification within 30 days, or within 60 days for all other appeals.**

- If the appeal is about plan design, Aetna will decide it.
- *If the appeal involves a medical judgment, request a review by an IRO.* The appeal will be randomly assigned to one of three IROs for review and an opinion. (MCMC of Bethesda, MD, IMEDECS of Lansdale, PA, and AMR of Los Angeles, CA.)

The IRO will provide written notice of its decision within 45 days after receiving the request for external review*. If Aetna's final denial is reversed, Aetna is required to pay the claim promptly.*

If your Level II appeal is denied or the decision by Aetna or the IRO was unsatisfactory, you may file a Level III appeal.

Level III Appeal for Medical, Vision/Audio

If your level II appeal is denied, you have the right under Alaska laws to file a Level III appeal to the Office of Administrative Hearings (OAH) **within 30 days of the date of your Level II or IRO decision.**

AS 39.35.006 authorizes any member or beneficiary under the Alaska Retirement Plan to appeal a decision made by the administrator or third-party administrator (TPA) of the Plan, such as Aetna, to the Alaska Office of Administrative Hearings (OAH). This same appeal right exists under the other retirement statutes, such as TRS.

Under the statute, OAH has 120 days after receiving the appeal to prepare a proposed decision. The involved parties can extend this by mutual agreement.

The procedure for an OAH appeal is set in Alaska Administrative Code at 2 AAC 64.110-340.

1. Submit a written request to appeal any medical claim denial to the Division of Retirement and Benefits (DRB) at one of its offices in Juneau, Anchorage, or Fairbanks. *You must request DRB to file the appeal with OAH. You may not file an appeal directly with OAH.*

2. Two forms must be used as part of submitting an appeal to OAH:
   - AlaskaCare Retiree Health Plan Notice of Appeal, which will be sent to you by DRB with the final Aetna appeal decision.
   - AlaskaCare Authorization for the Use and Disclosure of Protected Health, available at: http://doa.alaska.gov/drb/pdf/forms/ben043.pdf)

   Other documents submitted must be typed or printed on 8½ by 11-inch white paper and contain the following information:

   a. Your name, mailing address and contact telephone number;
   b. The date of the decision which is the subject of the appeal;
   c. The name and address of DRB;
      State of Alaska
      Division of Retirement and Benefits: Health Appeals
      POB 110203
      Juneau, AK 99811-0203
   d. A brief statement of the issue you are requesting OAH to review.

3. Mail your Level III packet to the above address. On receipt of a Level III appeal, the DRB Chief Health Official has 10 days to accept or reject your appeal. The official will review the Level I and II denials to determine if Aetna has completed all steps it is required to complete. If it hasn't, the appeal will be sent back to Aetna to complete.

4. If Aetna has completed all Level I and II steps, DRB will prepare the Level III appeal and send it to the Office of Administrative Hearings (OAH) within 15 days after DRB received your appeal.

Note: If DRB finds that Aetna has not completed its part of the appeals process, DRB will not be able to complete the OAH packet within 15 days. Should this happen causing you harm by the delay, please contact: Michele Michaud, Chief Health Officer at DRB (michele.michaud@alaska.gov) or Larry Davis, the Appeals and Risk Mitigation Manager (larry.davis@alaska.gov). Also advise RPEA at sharonhoffbeck@gmail.com.

5. Once an appeal is filed, you will be notified by OAH. During the appeal, you are entitled to engage in any of the alternative dispute resolution procedures. These include mediation, settlement conference or arbitration. They are used to see if a mutually agreeable solution can be found before the appeal proceeds.

6. You will receive a routine letter that an Assistant Attorney General will represent the State or DRB. This is normal procedure. A person filing an appeal may be represented by an attorney but that is not required. Individuals may represent themselves in OAH appeals.

7. The administrative law judge (ALJ) assigned to your appeal will likely hold a pre-hearing conference to discuss the availability of alternative dispute resolution procedures. During the conference, the judge will discuss and establish the structure of and preparation for the hearing. You are entitled to request disclosure of any information that DRB or Aetna may have that is relevant to your appeal. The ALJ may prohibit the disclosure of any confidential information and may close any portion of a hearing to protect the privacy of personal information.

8. The ALJ has 120 days from the date the appeal was received in the OAH to make a decision unless an extension is mutually agreed upon. The ALJ is required to forward the decision immediately after the appeal's conclusion to DRB.

9. *Although the OAH appeal is a formal legal proceeding, you are not required to be a lawyer or have specialized legal training or background to participate. In fact, the ALJ will likely make efforts to ensure you understand the process and your rights in a way you are able to understand. Do not be afraid or hesitate to ask the ALJ questions about anything you don't understand or that is confusing.*

If you still think you have been treated unfairly according to the plan or appeal procedures, the law allows you to appeal the matter to the Superior Court.

DENTAL APPEALS

The Dental appeal procedure is very similar to that for Medical Vision/Audio. However, some wording and addresses change. Please follow these instructions when making a Dental appeal. Moda and Delta are used interchangeably. Moda is the main corporate body for Oregon and Alaska. It represents Delta Dental through its division ODS (Oregon Dental Services).

Before you begin:

a. Read the Explanations of Benefits (EOB) or letter from Moda. Be sure you understand it. Read *the document's front and back for the explanation of coded remarks.*

b. *Contact your dental office to see if the claim needs additional detail. Sometimes the addition of a single word in the comments section is enough to have the claim approved. For example, if you have periodontal disease and need four cleanings annually, the words "periodontal disease" must be in the section called "Comments" when the dentist's office submits the claim.*

c. *Call Moda Health at 855-718-1768 if you need further clarification. Moda may be able to reprocess your claim in a timely manner. A request to reprocess a claim is* ***not*** *the same as an official Level I appeal.*

URGENT APPEALS WHEN DELAY IS HARMFUL

If you have received a denial for a procedure or treatment and your provider determines that a delay could harm your health, you and your provider can contact Moda. Call 855-718-1768 to request an expedited appeal. Moda should respond no later than 72 hours following receipt of your Level I or Level II appeal request for an expedited appeal.

Level One Appeal Dental

Once you have decided to appeal the denial of your claim or precertification print a copy of the ODS complaint and appeal form at https://www.modahealth.com/pdfs/ak/grievance_form.pdf. If you don't have Internet access call Moda at 855-718-1768 and ask to have a copy sent to you.

1. The 2014 Plan Amendment specifies that ***any appeal must be in writing and be received within 180 days of the date the Explanation of Benefits (EOB) or Pre-Certification denial***. Include only information relevant to the claim. **Be factual,** not emotional. The decision on your appeal will be based on the facts.

2. We recommend that you use the following language we have developed as part of your cover page for your letter. The MODA appeal form can be attached to this.

URGENT APPEALS WHEN DELAY IS HARMFUL

If you have received a denial for a procedure or treatment and your provider determines that a delay could harm your health, you and your provider can contact Moda. Call 855-718-1768 to request an expedited appeal. Moda should respond no later than 72 hours following receipt of your Level I or Level II appeal request for an expedited appeal.

I am appealing the denial of coverage for_____provided to me on _____, 20____.

The State of Alaska provides health benefits for individuals, including retirees, who are entitled to coverage under applicable statutes. These benefits are described in the Retiree Health Plan Booklet and include benefits under DVA for retirees who elect coverage. The benefits provided under this coverage cannot be diminished without an equal or greater offset of enhanced benefits.

- When I (or my spouse) retired in _____ (date of retirement) I/we opted for DVA coverage.
- Since I was a retiree entitled to benefits under PERS/TRS, I was entitled to elect DVA coverage.
- DVA coverage is described in the 2003 Retiree Insurance Information Booklet along with other medical coverage.
- I paid for DVA coverage through monthly withholdings from my monthly retirement payment.
- The DVA plan included_____treatment as a covered benefit in_____(year of retirement when coverage was elected) when I elected coverage.
- PERS/TRS retirement benefits, including medical benefits, are vested, constitutionally protected rights that cannot be diminished without an equal or greater enhancement.
- DOA has unilaterally diminished benefits available under the DVA plan described in the 2003 Retiree Benefits Booklet such as treatment for_____, and has not provided any enhanced benefits to the DVA plan to offset these diminished benefits.

Attached are the details of my appeal, and supporting documents.

You can copy this at:
http://rpea.apea-aft.org/medical/benefit_issues/2016/Recommended-cover-page-language-for-Dental-appeals.pdf

3. Your letter should include:
   a. Your mailing address and phone number.
   b. Name of patient.
   c. Name of Retiree/Subscriber and ID number.
   d. Group Number.
   e. Claim Number.
   f. Date of Service or Date of Denial for Certification.
   g. Include in your letter:
      - What decision you are appealing,
      - Moda's reason for denying your claim,
      - Why you disagree with its denial,
      - If you had this service or treatment and it was previously covered, note and document that.

4. Make copies of the Explanation of Benefits, correspondence, statements from providers and relevant records to include with your appeal letter. If you have had this procedure or service before and it was covered, include copies of EOBs showing that.

5. Mail your appeal letter as soon as possible after you receive the Explanation of Benefits to:

Moda Health Appeal Unit
Attn: AlaskaCare Member Appeal Level 1
601 SW Second Avenue
Portland OR 97204

6. **Always send the appeal, and any other communications, by priority or certified mail, return receipt requested. The receipt will prove that the appeal was received within the required time**. If you send by Priority Mail, request both a signature and tracking. *Moda does not have an office in Alaska where the appeal may be submitted in person.*

7. *Moda should respond no later than 60 days after receipt of an appeal of a claim denial. If appealing a Pre-certification, you should hear back within 30 days.* If you do not receive a timely response, *call Moda at 855-718-1768.*

8. If Moda does not send a written decision by those deadlines, treat that failure as a denial and proceed to Level II.

9. If you are not satisfied with the Moda Level I response, you may file a Level II appeal. (See below.)

Level II Appeal Dental

If your Level I appeal is not resolved to your satisfaction, or if Moda fails to issue a timely written decision, the next step is to file a Level II appeal. *There are two deadlines for this level appeal:*

1) If you're appealing based on the plan or policy itself that ***appeal must be in writing and should be received by Moda within 180 days*** of the date the Level I decision letter was issued (date on the letter).

2) **But, if you wish to file an *appeal based on medical judgment or necessity, that appeal must be received by Moda within four months or 120 days of the date on your level I decision letter***.

3) **As with the initial appeal, send the appeal, and any other communications, by priority or certified mail, return receipt requested. The receipt will prove that the appeal was received within the required time**. If you use Priority Mail, request both a signature and tracking.
Mail your appeal to:

Moda Health Appeal Unit
Attn: AlaskaCare Member Appeal Level II
601 SW Second Avenue
Portland OR 97204

Individuals who were not involved in the review of your Level I appeal will review your Level II appeal. **Moda is required to respond to an appeal regarding precertification within 30 days, or within 60 days for all other appeals.**

- If the appeal is about plan design, Moda will decide it.
- *If the appeal involves a medical judgment, request a review by an IRO.* Then the appeal will be randomly assigned to one of three IROs for review and an opinion. (ProPeer, Medical Consultants Network, LLC (MCN) and MCMC, LLC.)

The IRO will provide written notice of its decision within 45 days after receiving the request for external review*. If Moda's final denial is reversed, Moda is required to pay the claim promptly.*

If your Level II appeal is denied or the decision by Moda or the IRO was unsatisfactory, you may file a Level III appeal.

Level III Appeal for Dental

If your Level II appeal is denied, you have the right under Alaska laws to file a Level III appeal to the Office of Administrative Hearings (OAH) **within 30 days of the date of your Level II or IRO decision.**

AS 39.35.006 authorizes any member or beneficiary under the Alaska Retirement Plan to appeal a decision made by the administrator, or third-party administrator (TPA) of the Plan, such as Moda, to the Alaska Office of Administrative Hearings (OAH). This same right of appeal exists under the other retirement statutes, such as TRS.

Under statute, OAH has 120 days after receiving the appeal to prepare a proposed decision. The involved parties can extend this by mutual agreement.

The procedure for an OAH appeal is set in Alaska Administrative Code at 2 AAC 64.110-340.

1. Submit a written request to appeal any dental claim denial with the Division of Retirement and Benefits (DRB) at one of its offices in Juneau, Anchorage, or Fairbanks. *You must request DRB to file the appeal with OAH and may not file an appeal directly with OAH.*

2. Two forms must be used as part of submitting an appeal to OAH:
   - AlaskaCare Retiree Health Plan Notice of Appeal, which will be sent to you by DRB after the final Moda appeal decision.

- AlaskaCare Authorization for the Use and Disclosure of Protected Health Information, available at: http://doa.alaska.gov/drb/pdf/forms/ben043.pdf)

Other documents submitted must be typed or printed on 8½" by 11" white paper and contain the following information:

a. Your name, mailing address and contact telephone number;
b. The date of the decision which is the subject of the appeal;
c. The name and address of DRB;
   State of Alaska
   Division of Retirement and Benefits: Health Appeals
   POB 110203
   Juneau, AK 99811-0203
d. A brief statement of the issue you are requesting OAH to review.

3. Mail your Level III packet to the above address. On receipt of a Level III appeal, the DRB Chief Health Official has 10 days to accept or reject your appeal. The official will review the Levels I and II denials to determine if Moda has completed all steps it is required to complete. If it hasn't, the appeal will be sent back to Moda to complete.

Note: If DRB finds that Moda has not completed its part of the appeals process, DRB will not be able to complete the OAH packet within the 15 days. Should this happen causing you harm by the delay, please contact: Michele Michaud, Chief Health Officer at DRB (michele.michaud@alaska.gov) or Larry Davis, the Appeals and Risk Mitigation Manager (larry.davis@alaska.gov). Also advise RPEA at manager@rpea-ak.org.

4. If Moda has completed all of the Level I and II steps, DRB will prepare the Level III and send it to the Office of Administrative Hearings (OAH) within 15 days after DRB received your appeal.

5. Once an appeal is filed, you will be notified by OAH. In the appeal, you are entitled to engage in any of the alternative dispute resolution procedures. These include mediation, settlement conference or arbitration. They are used to see if a mutually agreeable solution can be found before the appeal proceeds.

6. You will receive a routine letter that an Assistant Attorney General will represent the State or DRB. This is normal procedure. *A person filing an appeal may be represented by an attorney but that is not required. Individuals may represent themselves in OAH appeals.*

7. The administrative law judge ("ALJ") assigned to your appeal will likely hold a pre-hearing conference to discuss the availability of alternative dispute resolution procedures. During the conference, the judge will discuss and establish the structure of

and preparation for the hearing. You are entitled to request disclosure of any information that DRB or Moda may have that is relevant to your appeal. The ALJ may prohibit the disclosure of any confidential information, and may close any portion of a hearing to protect the privacy of personal information.

8. The ALJ has 120 days from the date the appeal was received in the OAH to make a decision unless and extension is mutually agreed upon. The ALJ is required to forward the decision immediately after the appeal's conclusion to DRB.

9. *Although the OAH appeal is a formal legal proceeding, you are not required to be a lawyer or have specialized legal training or background to participate. In fact, the ALJ will likely make efforts to ensure you understand the process and your rights in a way you are able to understand. Do not be afraid or hesitate to ask the ALJ questions about anything you don't understand or that is confusing.*

If you still think you have been treated unfairly according to the plan or appeal procedures, the law allows you to appeal the matter to the Superior Court.