APPEALING A CLAIM or Pre-certification DENIAL
For issues that have occurred since 1/1/18[1]

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. However, on 1/1/18 they amended the appeal process to again include DRB in the appeal process. The 1/1/18 amendment supersedes the 1/1/14 and 7/1/05 amendments.

The appeal information below is based on provisions in the 1/1/18 Amendment and information that RPEA received from DRB. As we receive updated information, we will endeavor to revise the instructions below.

All initial claims for benefits MUST be filed and received by DRB as soon as possible but no later than 12 months from the date the expenses were incurred. Urgent Care claims should be no later than 24 hours.

<u>New Appeal Levels</u>
The appeal process now has four levels instead of three. (DRB is again 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:	Division of Retirement and Benefits (DRB) appeal
Level IV:	Office of Administrative Hearings (OAH)**

[1] NOTE: RPEA has developed these appeal instructions in an effort to help retirees better understand the appeals procedures recently imposed by DRB under the AlaskaCare Retiree Health Plan. These instructions are not intended to provide any sort of legal advice or direction. Each retiree should read the new 2018 appeals procedure adopted by DRB which govern any appeal submitted. These instructions are meant to make that new appeal procedure more understandable but should not be viewed or used as the actual appeal procedure. Each retiree must understand that use of these instructions are to assist only but not control any particular appeal filed.

*IROs are companies hired by Aetna or Moda/Delta Health to independently review 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 IV appeals and independently determine the claim appeal based on Alaska law.

Remember **all appeals must be in writing** under the 1/1/18 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 1/1/18 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 and AUDIO:

Before you begin:

The retiree plan currently consists of the 2003 Retiree Benefit Book, which includes the 2018 ammendment.

a. *The retiree plan currently consists of the 2003 Retiree Benefit Book with the 2018 ammendments can be found at*
http://doa.alaska.gov/drb/pdf/ghlb/retiree/RetireeInsuranceBooklet2003with2018amendment.pdf
the 1/1/14 ammendment at:
http://doa.alaska.gov/drb/pdf/ghlb/retiree/retireePlanAmendment12312013.pdf - zoom=100
the 2016-1and 2 ammendments at:
http://doa.alaska.gov/drb/pdf/ghlb/retiree/retireePlanAmendment01012016.pdf
http://doa.alaska.gov/drb/pdf/ghlb/retiree/retireePlanAmendment05252016.pdf

b. *Review these documents under the*
http://doa.alaska.gov/drb/alaskacare/retiree/publications/booklets.html 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 or dental providers. The log should include the date, time, representative's name and a summary of each conversation. Ask the represenstive for your call number and log it. They record each call and this will help locate your conversation in the future if nessary. If possible, speak to the same representative each time. *If you talk to a helpful representative, ask for that person's direct extension number.*

If you made a mistake and submitted an incomplete claim you will be notified one of two ways:
1) Orally of the additional information needed to complete your claim. That should occur no later than 24 hours from when the claims administrator receives your *urgent* claim;
2) In writing no later than 15 calendar days from when the claims administrator receives your *pre-service* claim; or
3) In writing no later than 30 calendar days from when the claims administrator receives your *post-service* claim.

If, because of matters beyond the claims administrators control, they cannot meet these time limits for pre and post-service claims they will be granted a one-time 15 day extension.

Ongoing Treatments

If the claims administrator has approved an on-going course of treatment that is to be given to you over a period of time for a certain number of treatments, *any reduction or termination* by the claims administrator will be considered a denial and may be appealed. You will be notified before the termination or reduction of treatments, so you have a reasonable time to appeal that decision.

Level I Appeal for Medical, Vision/Audio

1. When you decide to appeal a denial, write your appeal letter. *The 2018 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.

We recommend you use the following language RPEA developed as part of the cover page for your appeal: (You can copy this at: http://www.rpea.apea-aft.org/medical/benefit_issues/2016/Recommended-cover-page-language-for-Medical-Appeals.pdf

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.

2. 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.

3. 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.

4. 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
FAX: (859) 425-3379

5. **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.*

6. *It is the practice of Aetna to 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.*

   If you do not receive a postcard acknowledging their receipt of your appeal, call Aetna to confirm they have received your appeal. If they ***cannot*** *confirm they have received it, we recommend you call back every other day until they can confirm they have your appeal.*

   If Aetna cannot confirm they have your appeal after 20 days send a copy of your appeal to:
   Michele Michaud, Chief Health Officer, Division of Retirement and Benefits
   POB 110203
   Juneau, AK 99911-0203

   Explain when you sent the appeal in and that Aetna cannot find it. Ask that she deliver it to Aetna. However, Aetna is 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.*

7. If Aetna does not send a written decision by those deadlines, treat that failure as a denial. If Aetna fails to comply with its timelines on appeal, send a letter to DRB stating that you wish to file an appeal to the Office of Administrative Hearings because Aetna has failed to comply with the appeal timelines and has waived its right or authority to review or rule on the appeal any further.

8. If you are **appealing a precertification denial**, Aetna should send you a written decision within 30 calendar days after the receipt of your appeal. If your precertification denial is not eligible for external review Aetna will send you a written decision within 15 calendar days after receiving your request.

9. If you are **appealing a claim denial** Aetna will issue a written decision within 60 calendar days after receipt of your appeal or 30 calendar days if not eligible for external

review.

10. 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
FAX: (859) 425-3379

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 15 days, or within 30 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 (*Independent Review Organization)
- 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 Aetna does not send a written decision by those deadlines, treat that failure as a denial. If Aetna fails to comply with its timelines on appeal, send a letter to DRB stating that you wish to file an appeal to the Office of Administrative Hearings because Aetna has failed to comply with the appeal timelines and has waived its right or authority to review or rule on the appeal any further.

NOTE:

If you do not receive a postcard acknowledging their initial receipt of your Level II appeal, call Aetna at 855-784-8646 to confirm they have received your appeal. If they ***cannot*** *confirm they have received it, we recommend you call back every other day until they can confirm they have your appeal.*

If Aetna cannot confirm they have your appeal after 20 days send a copy of your appeal to:

Michele Michaud, Chief Health Officer, Division of Retirement and Benefits
POB 110203
Juneau, AK 99911-0203

Explain when you sent the appeal in and that Aetna cannot find it. Ask that she deliver it to Aetna.

If your Level II appeal is denied or the decision by Aetna or the IRO was unsatisfactory, you may file a Level III appeal to the Division of Retirement and Benefits.

Level III Appeal to the Division of Retirement and Benefits

If your level II appeal is denied on external review or if not eligible for an external review at the II level, you may send a written appeal to the Division of Retirement and Benefits.

If you choose to make an appeal of your level II decision your appeal packet must be either postmarked or received by the Division of Retirement and Benefits no later than 60 calendar days from the date of the external review or second level claims administrators letter.

Include in your appeal letter any additional information you wish considered when deciding your appeal. The Division will request a copy of your Claims Administrators file and needed information from your provider. The Division will review your appeal to see if it relates to the terms and coverage of the health plan. If your appeal involves medical judgement, including but not limited to the health plans requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or that a treatment is experimental or investigational; the Division may refer your appeal to a second IRO in cases where the initial IRO is deemed inadequate or that substantial new clinical evidence is provided that was not available during the first IRO review.

The Division will issue a written decision of your third level appeal within 60 calendar days from the receipt of your third level appeal. If your Level III appeal is denied or the decision by the Division of Retirement and Benefits was unsatisfactory, you may file a Level IV appeal.

Level IV Appeal to the Office of Administrative Hearings

If your level III appeal is denied, you have the right under Alaska laws to file a Level IV appeal to the Office of Administrative Hearings (OAH) **within 30 days of the date you receive notice of your Level IV 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 or Anchorage. *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 IV packet to the above address.
4. 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.
5. 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.
6. 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.

7. 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.

8. *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.

<<<<>>>>

We at RPEA would appreciate it if you would contact us and let us know the results of your appeal. It may help us with other retirees going through this process. Send it to manager@rpea-ak.org.