

APPEALS PROCESS NOTICE

INTERNAL APPEAL PROCESS

If you wish to appeal an adverse decision or make a grievance to resolve a dispute with NHHP, you must file an appeal in writing with NHHP at the address shown at the end of this notice identifying the determination or grievance you wish to appeal. You may authorize a representative to pursue a grievance or an appeal for you by submitting to NHHP at the same address a written statement that identifies your representative and states that the representative may act on your behalf regarding the grievance or appeal. Your provider may also assist you with the grievance or appeal and provide information related thereto to NHHP. If, however, your provider files the appeal, or is involved in providing information to NHHP, NHHP is obligated only to provide notification to you or your duly authorized representative of determinations or requests related to the appeal for the notice to be effective. Our appeal process involves two levels of appeal: a first, mandatory, level of appeal after the initial determination, and then a second, non-mandatory, level of appeal. Our appeal process also provides for an expedited review when your medical circumstances require it. These levels of appeal and the expedited process are outlined below. PLEASE NOTE THAT YOU MAY NOT BRING A LAWSUIT WITH RESPECT TO ANY GRIEVANCE OR DISPUTE WITH NHHP REGARDING AN ADVERSE DETERMINATION UNTIL AFTER YOU HAVE EXHAUSTED THE MANDATORY (I.E. FIRST) LEVEL OF THIS APPEALS PROCESS, UNLESS OTHERWISE PROVIDED BY APPLICABLE LAW.

Mandatory – First Level Appeal

A Mandatory First Level Appeal will be conducted as follows:

I. Process

- (a) The persons reviewing the grievance shall not be the same person or persons making the initial determination, and shall not be subordinate to or the supervisor of the person making the initial determination;
- (b) For medical necessity appeals at least one person reviewing the appeal will be a practitioner in the same or similar specialty who typically treats the medical condition, performs the procedure, or provides the treatment at issue in the appeal. A practitioner is considered of the same specialty if he or she has similar credentials and licensure as those who typically treat the condition or health problem in question in the appeal. A practitioner is considered of a similar specialty if he or she has experience treating the same problems as those in question in the appeal, in addition to expertise treating similar complications of those problems;
- (c) You have 180 days following receipt of a notification of a claim denial to file your appeal;
- (d) You may submit written comments, documents, records, and other information relating to the claim without regard to whether those documents or materials were considered in making the initial determination;
- (e) We will provide to you, upon request, and without charge, reasonable access to, and copies of all documents, records, and other information relevant to or considered in making the initial adverse claim determination; and
- (f) The review shall be a de novo proceeding and shall consider all information, documents, or other material submitted in connection with the appeal without regard to whether the information was considered in making the denial.

II. Appeals Involving Medical Judgment. In addition to the procedures outlined in section I above, if the appeal of a claim denial is based in whole or in part on a medical judgment, the following shall apply:

- (a) The review shall be conducted by or in consultation with a health care professional in the same or similar specialty who typically treats the medical condition, performs the procedure, or provides the treatment at issue in the appeal. A practitioner is considered of the same specialty if he or she has similar credentials and licensure as those who typically treat the condition or health problem in question in the appeal. A practitioner is considered of a similar specialty if he or she has experience treating the same problems as those in question in the appeal, in addition to expertise treating similar complications of those problems;
- (b) The titles and qualifying credentials of the person conducting the review shall be included in the decision; and
- (c) The identity and qualifications of any medical or vocational expert whose advice was considered, without regard to whether it was relied upon in making the initial claim denial, shall be made available to the claimant upon request.

III. Expedited Appeals. In the appeal of a claim for urgent care, a claim involving a matter that would seriously jeopardize the life or health of a covered person or would jeopardize the covered person's ability to regain maximum function, or a claim concerning an admission, availability of care, continued stay or health care service for a person who has received emergency services, but who has not been discharged from a facility, an expedited appeal process is available as follows:

- (a) You may submit of information to NHHP by telephone, facsimile, or other expeditious method; and
- (b) We will make a determination of the appeal not more than 72 hours after the submission of the request for appeal.

IV. Timing and Notification for Determination on Appeal

- (a) In the case of non-expedited appeal of a pre-service claim or post-service claim, the determination on appeal shall be made within a reasonable time appropriate to the medical circumstances, but in no event more than 30 days after receipt by NHHP of your appeal.
- (b) In the case of an expedited appeal related to an urgent care claim, we will make a determination and notify you as expeditiously as your medical condition requires, but in no event more than 72 hours after the appeal is filed. If the expedited review involves ongoing urgent care services, the service shall be continued without liability to you until you have been notified of the determination. Notification to you may be made by telephone, email, facsimile, or other expeditious method; NHHP will also provide written confirmation of its decision concerning an expedited review within 2 business days of providing notification of that decision, if the initial notification was not in writing.
- (c) The period of time within which a decision shall be rendered on appeal shall begin to run at the time the appeal is filed in accordance with these appeal procedures, without regard to whether all the information necessary to make a determination on appeal is contained in the filing. In the event you fail to submit information necessary to decide the appeal, the period for making the determination on appeal shall be tolled from the date NHHP notifies you in writing of precisely what is required until the date you respond, in writing, to the request. NHHP will notify you of incompleteness as soon as possible; if your appeal involves urgent care, we will notify you of incompleteness no more than 24 hours after the filing of the appeal. In the event that you fail to

provide to NHHP within 45-days of date of notification of incompleteness sufficient information to decide the appeal, NHHP may deny the appeal on the basis of incompleteness. NHHP may reopen the appeal upon receipt of the required information.

V. Manner and Content of Notification of Determination on Appeal

- (a) NHHP will provide you with a written determination of the appeal that will include:
- (1) The specific reason or reasons for the determination, including reference to the specific provision, rule, protocol, or guideline on which the determination is based;
 - (2) A statement that the rule, protocol, or guideline governing the appeal will be provided without charge to you upon request;
 - (3) A statement describing all other dispute resolution options available to you, including, but not limited to, other options for internal review and options for external review and options for bringing a legal action;
 - (4) A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;
 - (5) If NHHP relied upon an internal rule, guideline, protocol, or other similar criterion in making the claim denial, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the claim denial and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request;
 - (6) If the claim denial is based on a medical necessity or experimental treatment or similar exclusion or limit, NHHP will provide to you either (i) an explanation of the scientific or clinical judgment for the denial, applying the terms of the plan to the claimant's medical circumstances, or (ii) a statement that such explanation will be provided free of charge upon request;
 - (7) The following statement: ""You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency;" and
 - (8) A statement describing your right to contact the insurance commissioner's office for assistance which shall include the toll-free telephone number and address of the commissioner.

Non-mandatory – Second Level Appeal

In any case where the Mandatory First Level Appeal review process does not resolve a difference of opinion between you or your provider and NHHP, you may elect to pursue the appeal with NHHP at a second level of review by requesting, in writing, that NHHP review the appeal or grievance (your provider may assist you or file the appeal on your behalf unless the provider is prohibited from filing a grievance by federal or other state law). NHHP will review it as a Voluntary **Second Level Appeal**.

I. With respect to the Second Level Appeal

- (a) You may elect to pursue this Second Level Appeal voluntarily; you are not required to pursue a Second Level Appeal;

- (b) If you choose not to follow this Second Level Appeal, NHHP will not assert against you the failure to exhaust administrative remedies if you pursue a claim through other venues, such as the court system, rather than through this voluntary second level of appeal;
- (c) Any statute of limitations or time limits to pursue other remedies shall be tolled (i.e. suspended) during the voluntary second level appeal process;
- (d) This Second Levels of Appeal is available only after you have completed the mandatory First Levels Appeal process;
- (e) No fees or costs associated with this voluntary Second Level Appeal will be imposed on you; and
- (f) The Second Level Appeal process shall be completed within 30 days from the date of the request for the voluntary Second Level Appeal.

II. A Voluntary, Second Level Appeal will be conducted as follows:

- (a) The second level appeal review panel will be established to give those who are dissatisfied with the first level appeal review decision the option to request a second level review. A majority of the panel will be comprised of persons who were not previously involved in the grievance or appeal. The panel will consult with at least one clinical peer who has the appropriate expertise to review a grievance involving the adverse determination.
- (b) You and/or your authorized representative(s) may notify NHHP of your choice to appear in person before the review panel. If so, the panel will make reasonable attempts to provide notice to you of the time, and place of the review meeting. You will be notified at least 3 business days in advance of the review meeting date.
- (c) At your request, NHHP will provide you with all the relevant information that is not confidential or privileged.
- (d) The review panel will issue a written decision to you within 5 business days of completing the review meeting, but no more than 30 days after you filed your notice of appeal for the Second Level Appeal. Upon your concurrence, a copy of the decision will be forwarded to the Insurance Department.
- (e) With respect to an appeal that was expedited at the Mandatory First Level of Appeal, (i) You may file the Second Level Appeal and submit information related thereto to NHHP by telephone, facsimile, or other expeditious method. (ii) NHHP shall conduct the review and adhere to time frames that are reasonable under the circumstances, attempting in good faith to make a determination of the appeal not more than 72 hours after the submission of the request for appeal.

EXTERNAL REVIEW PROCESS

An independent **External Review Process** through the Department of Insurance is available to you if the **First Level Appeal** does not resolve the difference of opinion; if the NHHP has agreed to submit the determination to **External Review** prior to completion of the internal review process; or if you have requested a **First Level Appeal** or a **Second Level Appeal**, standard or expedited review and have not received a decision from the NHHP within the required time frames.

You or your representative must submit the request for an **External Review** in writing to the Commissioner of Insurance within:

- (1) 180 days of the date of the **Second Level Appeal** denial decision; or
- (2) if there is a failure to make a **First Level Appeal** or a **Second Level Appeal**, standard or expedited review decision that is past due, within 180 days of the date the decision was due.

You or your representative's participation in a **Second Level Appeal** shall not affect your ability to submit a request for an **External Review**. In the event that you or your representative elects to proceed with a **Second Level Appeal**, you will have 180 days from the date the decision is rendered on the **Second Level Appeal** to submit a request for an **External Review**.

The cost for the service, supply, or drug that is the subject of the adverse determination must be, or is anticipated in a 12-month period to be, equal to or in excess of \$400.

The request for an **External Review** must not be for the purpose of pursuing a claim or allegation of health care provider malpractice, professional negligence, or other professional fault.

Standard External Review

Within 7 business days after the date of receipt of a request for an **External Review**, the Commissioner shall complete a preliminary review of the request for an **External Review** to determine whether:

- (1) you are or were a covered person under the health benefit plan;
- (2) the determination that is the subject of the request for an **External Review** meets the conditions of eligibility; and
- (3) you have provided all the information and forms required by the Commissioner that are necessary to process a request for an **External Review**.

Upon completion of the preliminary review, the Commissioner shall immediately notify you or your representative in writing whether the request is complete and whether the request has been accepted for **External Review**.

If the request is not complete, the Commissioner shall inform you or your representative what information or documents are needed to make the request complete and to process the request. You or your representative shall submit such information or documentation within 10 days of being notified that the request was incomplete.

If the request for **External Review** is accepted, the Commissioner shall:

- (1) include in the notice provided, a statement that if you wish to submit new or additional information or to present oral testimony via teleconference, such information shall be submitted, and the oral testimony shall be scheduled and presented, within 20 days of the date of issuance of the notice. However, the notice shall also explain that oral testimony shall be permitted only in cases when the Commissioner determines, based on evidence provided by you, that it would not be feasible or appropriate to present only written testimony; and
- (2) immediately notify the NHHP in writing of the request for an **External Review** and its acceptance.

If the request for an **External Review** is not accepted, the Commissioner shall inform you or your representative and the NHHP in writing of the reason for its non-acceptance.

At the time a request for **External Review** is accepted, the Commissioner shall select and retain an independent review organization that is certified pursuant to New Hampshire law to conduct the **External Review**. The Commissioner shall not select the same independent review organization for each **External Review**, but shall rotate among the certified independent review organizations, using all organizations equally. The Commissioner may select and retain an independent review organization regardless of the rotation if the Commissioner determines that the use of such independent review organization is necessary for the fair adjudication of the case in question.

Within 10 days after the date of issuance of the notice from the Commissioner of Insurance to the NHHP informing of the request for **External Review** and its acceptance, the NHHP or its designated utilization review organization shall provide to the selected independent review organization and to you all information in its possession that is relevant to the adjudication of the matter in dispute, including but not limited to:

- (1) the terms of agreement of the health benefit plan, including the evidence of coverage, benefit summary, or other similar document;
- (2) all relevant medical records, including records submitted to the NHHP by you, your representative, or your treating provider;
- (3) a summary description of the applicable issues, including a statement of NHHP's final determination;
- (4) the clinical review criteria used and the clinical reasons for the determination;
- (5) the relevant portions of the NHHP's utilization management plan;
- (6) any communications between you and the NHHP regarding the internal review process or the **External Review**; and
- (7) all other documents, information, or criteria relied upon by the NHHP in making its determination.

Failure by the NHHP or you to provide the documents and the required information within the specified time frame shall not delay the conduct of the **External Review**.

The selected independent review organization shall review all of the information and documents received from the NHHP and any other information submitted by you or your representative or treating provider with the request for **External Review** and any testimony provided. In addition to the information provided by the NHHP and you or your representative or treating provider, the independent review organization may consider any applicable, generally accepted clinical practice guidelines, studies or research, including those developed or conducted by the federal government, national or professional medical societies, boards, and associations. The independent review organization shall consider anew all previously determined facts, allow the introduction of new information, and make a decision that is not bound by decisions or conclusions made by the NHHP during the internal review process.

The selected independent review organization shall render a decision upholding or reversing the determination of the NHHP and notify you or your representative and the NHHP in writing within 20 days of the date that any new or additional information from you is due pursuant to New Hampshire law. This notice shall include a written review decision that contains a statement of the nature of the grievance, references to evidence or documentation considered in making the decision, findings of fact, and the clinical and legal rationale for the decision, including, as applicable, clinical review criteria and rulings of law.

Expedited External Review

Expedited External Review shall be available when your treating provider certifies to the Commissioner of Insurance that adherence to the time frames specified by New Hampshire law for the **Standard External Review** would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function.

Except to the extent that it is inconsistent with the provisions of an **Expedited External Review**, all requirements for the conduct of the **Standard External Review** process specified by New Hampshire law shall apply to the **Expedited External Review**.

At the time the Commissioner receives a request for an **Expedited External Review**, the Commissioner shall immediately make a determination whether the request meets the standard for **Expedited External Review**, as well as the reviewability requirements set forth in New Hampshire law. If the conditions are met, the Commissioner shall immediately notify the NHHP. If the request is not complete, the Commissioner shall immediately contact you or your representative and attempt to obtain the information or documents that are needed to make the request complete.

The Commissioner shall select and retain an independent review organization that is certified pursuant to New Hampshire law to conduct the **Expedited External Review**.

The NHHP or its designated utilization review organization shall provide or transmit the documents and information specified in New Hampshire law to the selected independent review organization by telephone, facsimile, or any

other available expeditious method within one business day of receiving the Commissioner's notice of the request for **Expedited External Review**.

When handling a review on an expedited basis, the selected independent review organization shall make a decision and notify the NHHP and you as expeditiously as your medical condition requires, but in no event more than 72 hours after the **Expedited External Review** is requested. If this notice is not in writing, within 2 business days after the date of providing this notice, the selected independent review organization shall:

- (a) provide written confirmation of the decision to you or your representative and the NHHP; and
- (b) include the required information as set forth under the **Standard External Review** notice requirements.

An **Expedited External Review** shall not be provided for determinations made by the NHHP on a retrospective basis.

You shall not be held liable to either the NHHP, the hospital, the physician, or the services provider for the cost of services in excess of the applicable copayment, coinsurance, or deductible incurred, pending the independent review organization's determination of an **Expedited External Review**.

If you would like assistance in filing a grievance you may contact NHHP at:

NHHP (BMI)
P.O. Box 1090
Great Bend, KS 67530
Toll-Free number (877) 888-NHHP (6447)

You have the right to contact the Commissioner's Office at any time. If you would like further assistance, you may contact the Commissioner's Office at:

Department of Insurance
21 South Fruit Street, Suite 14
Concord, NH 03301-2430
Telephone (603) 271-7973
Toll free number (800) 852-3416