State of Alaska Department of Administration Division of Retirement and Benefits	**AlaskaCare Retiree Health Plan Amendment**	**Number:** 2018-1 **Effective Date:** January 1, 2018
	Amends: **Amends:** (1) Appeals (2) Medical Expenses not Covered	**Review Date:** **Distribution:** Deputy Commissioner Chief Health Official Vendor Manager Appeals Supervisor Communications Supervisor Legal Counsel TPA File

The State of Alaska provides, by means of self-insurance, health benefits covering individuals entitled to coverage under AS 14.25, AS 22.25, AS 39.35 or former AS 39.37, and their dependents. Such benefits are set forth in the ***Retiree Insurance Information Booklet*** (the "Plan"). Under authority of AS 39.30.090-098, the Commissioner of Administration hereby amends the Plan as follows:

Section 1: Amended Provisions

APPEALS

Supersedes 1/1/2014 and 7/1/2005 amendments.

If a Claim is Denied

If a claim or precertification is denied, in whole or in part, your Explanation of Benefits (EOB) or letter from the claims administrator will explain the reason for the denial. If you believe your claim or precertification should be covered under the terms of

the health plan, you should contact the claims administrator to discuss the reason for the denial. If you still feel the claim or precertification denial should be covered under the terms of the health plan, you can take the following steps to file an appeal.

Initial Claim for Health Plan Benefits

Any claim to receive benefits under the health plan must be filed with the claims administrator on the designated form as soon as possible, but no later than 12 months after the date you incurred the expenses, and will be deemed filed upon receipt.

If you fail to follow the claims procedures under the health plan for filing an urgent care claim or a pre-service claim, you will be notified orally (unless you request written notice) of the proper procedures to follow, not later than 24 hours for urgent care claims and five days for pre-service claims. This special timing rule applies only to urgent care claims and pre-service claims that: (1) are received by the person or unit customarily responsible for handling benefit matters; and (2) specify a claimant, a medical condition or symptom, and a specific treatment, service, or product for which approval is requested.

You must submit any required physician statements on the appropriate form. If the claims administrator disagrees with the physician statement, the terms of the health plan will be followed in resolving any such dispute.

Initial Review of Health Plan Claims

If you submit an incomplete claim, you will be notified of additional information required:

- orally (unless you request written notice) of the additional information needed to decide the initial claim, not later than 24 hours after the receipt of the incomplete claim by the claims administrator for urgent care claims;

- in writing no later than fifteen calendar days after the receipt of the incomplete claim by the claims administrator for pre-service claims; or

- in writing no later than thirty calendar days after the receipt of the incomplete claim by the claims administrator for postservice claims.

For urgent care claims you must submit the additional information not less than 48 hours after the receipt of the notice from the claims administrator. For pre-service or post-service incomplete claims, the claims administrator may or may not allow an extension to the claims filing deadline, of up to 45 calendar days from receipt of the written notice, for you to provide additional information.

You will be notified of the approval or denial of an urgent care claim no later than 48 hours after the additional information is received by the claims administrator, or the end of the 48 hour time limit to submit the additional information whichever is earlier. You will be notified of the approval or denial of a pre-service or post-service claim no later than 15 calendar days after receipt of additional information requested, or the end of the time period given to you to provide the additional information, whichever is earlier.

When a claim for health benefits has been properly filed, you will be notified of the approval or denial:

- within 72 hours after receipt of claim by the claims administrator for urgent care claims;

- no later than 15 calendar days after receipt of claim by the claims administrator for pre-service claims; or

- no later than 30 calendar days after the receipt of claim by the claims administrator for post-service claims

For urgent care claims, the claims administrator will defer to the attending provider with respect to the decision as to whether a claim is an urgent care claim for purposes of determining the applicable time period.

For pre-service and post-service claims, the claims administrator will be granted a one-time 15-day extension if the circumstances are due to matters beyond the claim administrator's control, and the claims

administrator notifies you before the end of the initial timeframe as outlined above, the circumstances requiring such extension and the date the claims administrator expects to render a decision.

Initial Denial of Health Plan Claims

If any claim for health plan benefits is partially or wholly denied, you will be given notice which will contain the following items:

- the specific reasons for the denial;
- references to health plan provisions upon which the denial is based;
- a description of any additional material or information needed and why such material or information is necessary;
- a description of the review procedures and time limits, including information regarding how to initiate an appeal, information on the external review process (with respect to benefits under the health plan);
- the specific internal rule, guideline, protocol, or other similar criterion, if any, relied upon in making the denial, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon, with a copy free of charge upon request;
- if the denial is based on a medical necessity or an experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request;
- for urgent care claims, a description of the expedited review process applicable to such claims; and
- for denials of benefits under the health plan, (A) information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if

applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning), (B) the denial code and its corresponding meaning, as well as a description of the claims administrator's standard, if any, that was used in the denial of the claim, and (C) the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Services Act to assist individuals with the internal claims and appeals and external review processes.

For urgent care claims, the information in the notice may be provided orally if you are given notification within three days after the oral notification.

Ongoing Treatments

If the claims administrator has approved an ongoing course of treatment to be provided to you over a certain period of time or for a certain number of treatments, any reduction or termination by the claims administrator under such course of treatment before the approved period of time or number of treatments end will constitute a denial. You will be notified of the denial, in accordance with the timelines outlined above in *Initial Review of Health Plan Claims*, before the reduction or termination occurs, to allow you a reasonable time to file an appeal and obtain a determination on the appeal. With respect to appeals for benefits under the health plan, coverage for the ongoing course of treatment that is the subject of the appeal will continue pending the outcome of such appeal.

For an urgent care claim, any request by you to extend the ongoing treatment beyond the previously approved period of time or number of treatments will be decided no later than 24 hours after receipt of the urgent care claim, provided the claim is filed at least 24 hours before the treatment expires.

First Level Appeal of Health Plan Claim Denial

You may initiate a first level of appeal of the denial of a claim by filing a written claim appeal with the claims administrator within 180 calendar days of the date the Explanation of Benefits or pre-service denial letter was issued, which will be deemed filed upon receipt. If the appeal is not timely, the decision of the claims administrator will be the final decision under the health plan, and will be final, conclusive, and binding on all persons. For urgent care claims, you may make a request for an expedited appeal orally or in writing, and all necessary information will be transmitted by telephone, facsimile, or other similarly expeditious method.

Decision on First Level of Appeal of Health Plan Claim Denial

If appealing a pre-service denial that is not eligible for external review as outlined below in *Application and Scope of External Review Process for Benefits Under the Health Plan*, you will receive notice of the claims administrator's decision on the first level of appeal within 15 calendar days of the claims administrators' receipt of your appeal. If appealing a pre-service denial that is eligible for external review, you will receive notice of the claim administrator's decision on the first level of appeal within 30 calendar days of the claim administrator's receipt of your appeal.

If appealing a post-service claim denial that is not eligible for external review as outlined below in *Application and Scope of External Review Process for Benefits Under the Health Plan*, you will receive notice of the claim administrators' decision on the first level of appeal within 30 calendar days after the claims administrators' receipt of your appeal. If appealing a post-service claim denial that is eligible for external review, you will receive notice of the claim administrators' decision on the first level of appeal within 60 calendar days after the claims administrators' receipt of your appeal.

If the claim for benefits under the health plan is denied on the first level of appeal, the claims administrator will provide notice to you containing the information set forth below. If you do not file a timely second level of appeal, the decision on the first level of appeal

will be final, conclusive, and binding on all persons.

With respect to claims for benefits under the health plan, the claims administrator will provide you with the following information free of charge as soon as possible and sufficiently in advance of the date on which the notice of final denial is required that you have a reasonable opportunity to respond prior to that date: (A) any new or additional evidence considered, relied upon, or generated by the claims administrator (or at the direction of the claims administrator) in connection with the claim, and (B) any new or additional rationale that forms the basis of the claims administrator's final denial, if any.

In addition, if the claim under the health plan is denied on appeal (including a final denial), you will be given notice with a statement that you are entitled to receive, free of charge, access to and copies of all documents, records, and other information that apply to the claim. The notice will also contain:

- the specific reasons for the denial;
- references to applicable health plan provisions upon which the denial is based;
- a description of the review procedures and time limits, including information regarding how to initiate an appeal, and information on the external review process (with respect to benefits under the health plan);
- the specific internal rule, guideline, protocol, or other similar criterion, if any, relied upon in making the denial, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon, with a copy free of charge upon request;
- if the denial is based on a medical necessity or an experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request;

- for denials of benefits under the health plan, (i) information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning), (ii) the denial code and its corresponding meaning, as well as a description of the claims administrator's standard, if any, that was used in the denial of the claim, and (iii) the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Services Act to assist individuals with the internal claims and appeals and external review process; and

- for denials of benefits under the health plan, if the denial is a final denial, a discussion of the decision.

- The decision on review will be final, conclusive and binding on all persons.

Second Level Appeal of Denial of Claim

You may initiate a second level of appeal of the denial of a claim with the claims administrator, if the claim is not eligible for external review as outlined below in *Application and Scope of External Review Process for Benefits Under the Health Plan*, because it does not involve medical judgment or a rescission of coverage under the health plan.

You may initiate the second level of appeal by filing a written appeal with the claims administrator within 180 calendar days of the date the Level 1 decision letter was issued, which will be deemed filed upon receipt. If you do not file a timely second level of appeal, to the extent available under this section, the decision on the first level appeal will be the final decision, and will be final, conclusive and binding on all persons.

Decision on Second Level Appeal of Denial of Claim

The claims administrator will provide you with notice of its decision on the second level of appeal within 15 calendar days for precertification appeals or within 30 calendar days for post service appeals. If the claim is denied on the second level of appeal, the claims administrator will provide notice to you containing the information set forth above for *Decision on First Level of Appeal of Claim Denial*. The decision on the second level of appeal will be a final denial that is final, conclusive and binding on all persons.

Application and Scope of External Review Process for Benefits Under the Health Plan

Upon receipt of a final denial (including a deemed final denial) with respect to benefits under the health plan, you may apply for external review as provided below. Upon receipt of a denial with respect to benefits under the health plan that is not a final denial, you may only apply for external review as provided below regarding expedited external review for urgent care claims. The external review process will apply only to:

- a final denial with respect to benefits under the health plan that involves medical judgment, including but not limited to, those based on the health plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational; and

- a rescission of coverage under the health plan (whether or not the rescission has any effect on any particular benefit at that time).

Standard External Review Process for Claims for Benefits under the Health Plan

a. **Timing of Request for External Review**. You must file a request for external review of a benefit claim under the health plan with the claims administrator no later than the date which is four months following the date of receipt of a notice

of final denial. If there is no corresponding date four months after the date of receipt of such notice, then the request must be filed by the first day of the fifth month following receipt of the notice (*e.g.*, if a final denial is received on October 30, request must be made by the following March 1). If the last filing date would fall on a Saturday, Sunday, State holiday or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, State holiday or Federal holiday.

b. **Preliminary Review.** The claims administrator shall complete a preliminary review of the request for external review within five business days to determine whether (A) you are or were covered under the health plan at the time the covered service was requested or provided, as applicable; (B) the type of claim is eligible for external review; (C) you have exhausted (or are deemed to have exhausted) the health plan's internal claims; and (D) you have provided all the information and forms required to process an external review. The claims administrator shall issue a notification to the claimant within one business day of completing the preliminary review. If the request is complete, but ineligible for external review, the notification shall include the reasons for its ineligibility. If the request is not complete, the notification shall describe the information or materials needed to make the request complete, and you will be allowed to perfect the request for external review by the later of the four month filing period described above, or within the 48 hour period following the receipt of the notification.

c. **Referral to Independent Review Organization (IRO).** The claims administrator shall assign an independent review organization (IRO) to your request for external review. Upon assignment, the IRO will undertake the following tasks with respect to the request for external review:

Timely notify you in writing of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the IRO, within ten business days following the date of receipt of the notice,

additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.

Review all documents and any information considered in making a final denial received by the claims administrator. The claims administrator shall provide the IRO with such documents and information within five business days after the date of assignment of the IRO. Failure by the claims administrator to timely provide the documents and information shall not delay the conduct of the external review. If the claims administrator fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the final denial. In such case, the IRO shall notify you and the claims administrator of its decision within one business day.

Forward any information submitted by you to the claims administrator within one business day of receipt. Upon receipt of any such information, the claims administrator may reconsider its final denial that is the subject of the external review. Reconsideration by the claims administrator must not delay the external review. The external review may be terminated as a result of reconsideration only if the claims administrator decides to reverse its final denial and provide coverage or payment. In such case, the claims administrator must provide written notice of its decision to you and IRO within one business day, and the IRO shall then terminate the external review.

Review all information and documents timely received under a *de novo* standard. The IRO shall not be bound by any decisions or conclusions reached during the claims administrator's internal claims and appeals process. In addition to the information and documents provided, the IRO, to the extent the information and documents are available and the IRO considers them appropriate, shall further consider the following in reaching a decision: (i) your medical records; (ii) the attending health care professional's

recommendation; (iii) reports from appropriate health care professionals and other documents submitted by the claims administrator, you, or your physician; (iv) the terms of the applicable health plan to ensure that the IRO's decision is not contrary to the terms of the health plan, unless the terms are inconsistent with applicable law; (v) appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations; (vi) any applicable clinical review criteria developed and used by the health plan, unless the criteria are inconsistent with the terms of the health plan or with applicable law; and (vii) the opinion of the IRO's clinical reviewer(s) after considering the information described in this paragraph to the extent the information or documents are available and the clinical reviewer(s) consider appropriate.

d. **Notice of Final External Review Decision**. The IRO shall provide written notice of its decision within 45 days after the IRO receives the request for external review. Such notice shall be delivered to you and the claims administrator and shall contain the following: (A) a general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial); (B) the date the IRO received the assignment to conduct external review and the date of the decision; (C) references to the evidence or documentation, including specific coverage provisions and evidence-based standards, considered in reaching the decision; (D) a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied upon in making its decision; (E) a statement that the determination is binding except to the extent that other remedies may be available under state or Federal law to either the health plan or you; (F) a statement that you may file an administrative appeal to the

Office of Administrative Hearing; and (G) current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act.

e. **Reversal of Plan's Decision.** If the final denial of the claims administrator is reversed by the decision, the health plan **shall** immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for a claim, upon receipt of notice of such reversal.

f. **Maintenance of Records.** The IROs shall maintain records of all claims and notices associated with an external review for six years. An IRO must make such records available for examination by you, the claims **administrator**, or a State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

Expedited External Review Process for Health Plan

a. **Application of Expedited External Review.** The health plan shall allow you to make a request for expedited external review at the time you receive either:

A denial with respect to benefits under the health plan, if the denial involves a medical condition of you for which the timeframe for completion of an internal appeal of an urgent care claim would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an appeal of an urgent care claim; or

A final denial with respect to benefits under the health plan, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final denial concerns admission, availability of care, continued stay, or a health care item or service for which you received emergency services,

but have not been discharged from a facility.

b. **Preliminary Review.** Immediately upon receipt of a request for expedited external review, the claims administrator must determine whether the request meets the reviewability requirements set forth above. The claims administrator shall immediately send a notice that meets the requirements set forth for standard external review of you for its eligibility determination.

c. **Referral to Independent Review Organization (IRO).** Upon a determination that a request is eligible for expedited external review following the preliminary review, the claims administrator shall assign an IRO pursuant to the requirements set forth above for standard external review. The claims administrator must provide or transmit all necessary documents and information considered in making the denial or final denial determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, shall consider the information or documents described above under the procedures for standard external review. In reaching a decision, the assigned IRO shall review the claim *de novo* and is not bound by any decisions or conclusions reached during the claims administrator's internal claims and appeals process.

d. **Notice of Final External Review Decision**. The IRO shall provide notice of its decision, in accordance with the requirements set forth above, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing such notice, the assigned IRO shall provide written confirmation of the decision to you and the claims administrator.

Third Level – Division of Retirement and Benefits Appeal

If the claim is denied on external review or, if not eligible for external review, on the second level of appeal, you may send a written appeal to the Division of Retirement and Benefits. If you submit an appeal to the Division, your appeal must be postmarked or received within 60 calendar days of the date the final external review or second level claims administrator decision letter was issued. If you do not file a plan administrator appeal timely, to the extent available under this section, the decision on external review or, if not eligible for external review, the second level of appeal will be the final decision, and will be final, conclusive and binding on all persons.

Upon receipt of your request, the Division will request a copy of your claims administrator appeal file, including any documentation needed from your provider. You must submit any additional information not provided with the Level II or IRO level appeal that you wish considered with your written notice to the Division. The Division will review all information and documents to determine if it should be covered under the terms of the health plan. If the appeal involves medical judgment, including but not limited to, those based on the health plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination 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 if substantial new clinical evidence is provided that was not available during the initial IRO review. Otherwise, the Division will make a decision solely based on the whether the initial IRO decision was compliant with the provisions of the plan.

The Division will issue a written decision at the third level appeal within 60 calendar days after receipt of your request of your third level appeal.

Fourth Level - Office of Administrative Hearings Appeal

If you are not satisfied with the final Level III decision, you may submit a Level IV appeal to the State of Alaska's Office of Administrative Hearings.

You must submit your request and the following forms (provided with your Level III response) to the Division of Retirement and Benefits within 30 calendar days of the date of the final Level III decision:

- AlaskaCare Retiree Health Plan Notice of Appeal
- AlaskaCare Authorization for the Use and Disclosure of Protected Health Information (PHI)

Send this material to:

State of Alaska
Division of Retirement and Benefits
Attention: Health Appeals
P.O. Box 110203
Juneau, AK 99811-0203

Your appeal file will be forwarded to the Office of Administrative Hearings (OAH).

Medical Expenses Not Covered

The following provision is hereby repealed:

- Services, therapy, drugs, or supplies for sex transformations or related to sex change surgery or any treatment of gender identity disorders.

Amended provision to include the following limitation and exclusion:

- Any treatment, drug (excepting hormones and hormone therapy) and, service or supply related to changing sex or sexual characteristics, including: surgical procedures to alter the appearance or function of the body, and prosthetic devices.

Section 2: Conflict

In the event of a conflict between the language contained in this Amendment and previously adopted language contained in the Plan, the provisions of this Amendment shall control.

Section 3: Effective Date.

This amendment is effective for claims submitted for payment with dates of service on or after January 1, 2018.

Adopted this 29th day of December, 2017.

By: Leslie D Ridle

Leslie Ridle, Commissioner