

HMO Appeals & Strategy for Appealing Health Plan Decisions



HIAC-h1&2

If you have a complaint about your HMO's coverage or services (for example, if your HMO denies a claim), then you have the right to file an internal complaint with the HMO.

The appeal procedure

Minnesota law requires all HMOs to have a procedure for internal appeals. The procedure must have the following steps: (1) an initial review of your complaint, (2) an initial decision by the HMO, (3) a right to appeal if the decision goes against you, and (4) an appeal decision.

Obtain a copy of the appeal procedure

Your HMO must give you its appeal procedure in writing when you enroll. You may also call your HMO's customer representative and ask for a copy of the complaint procedure. If you tell the representative that you have a complaint, then the HMO must also send a complaint form for you to complete.

Start the procedure in writing

In most cases, in order to start the HMO's review process you must make a written complaint to the HMO. You may submit a letter or a completed complaint form provided by the HMO.

- 1. Initial review.** As part of the initial review, the HMO must provide for informal discussions and written correspondence between you and someone with the authority to help resolve your complaint.
- 2. Initial review decision.** The HMO must notify you of its initial decision in writing within 30 days of receiving your written complaint. The HMO may take a 14-day extension in certain circumstances, but it must tell you about the extension in advance.
- 3. Appeal of initial decision.** If the initial decision goes against you, you have the right to make a written request to appeal. The HMO must give you the option of having either a hearing (in which you present your position in person) or a written reconsideration (in which you present your position in writing.) You may support your position with testimony, letters, and explanations.
- 4. Appeal decision.** If you request a *hearing*, the HMO must give you a written decision within 45 days of your written notice of appeal. If you submit a *written reconsideration* request, the HMO must give you a written decision within 30 days of your written notice of appeal.

Emergency service—fast-track appeal

If you have a complaint about the HMO that involves an emergency, then you have a right to an expedited appeal. In these cases, your complaint does not have to be in writing.

Complaints to commissioners

At any time during the process, you may submit a complaint about your HMO to the Minnesota Commissioner of Health, (651) 282-5601 or (800) 657-3916; or the Commissioner of Commerce, (651) 296-2488 or (800) 657-3602.

Strategy for Appealing Health Plan Decisions



If you choose to appeal a decision of your health plan, it is important that you understand the appeals process and give the health plan as much information as possible to support your claim.

Obtain a copy of the appeal process

The appeal process for your health plan should be explained in your benefit plan. You may also contact your health plan and ask for a written copy of the appeal process.

Know the health plan's position

Your plan will send you a letter that explains why your request has been denied. Read the reasons carefully. Refer to your benefit plan contract for definitions of any terms used in the letter.

Write a letter

In most cases, in order to start the appeals process you must submit the appeal in writing. Use these guidelines to organize your letter:

- **Purpose:** State your purpose for writing.
- **Diagnosis:** Explain your child's diagnosis and how it affects your child.
- **Reasons:** Give specific reasons why your child needs the service.
- **Documentation:** Mention the supporting documentation you are including.
- **Action:** Close by requesting a written reply.

Personalize your request

Ask for letters of support from one or more doctors familiar with your child's case.

Keep records of phone conversations

For all phone conversations, keep a written record of the following:

- the date and time of your call
- the name of the person you spoke with
- what you discussed in the call

Create a paper trail

Create a paper trail by organizing the following:

- your policy
- copies of denial letters
- copies of any correspondence with your health plan
- detailed notes of conversations
- copies of any correspondence between your doctor and the health plan concerning your problem

Send copies

Send copies of all correspondence with your plan to all interested persons. For example, you may send copies to your physician, your employer's benefits manager or human resources director, the commissioner responsible for regulating the HMO, the head of the agency you are seeking services from (for example, the hospital administrator), and anyone else you have contacted regarding your situation. Indicate that you have sent copies by noting each name at the bottom of the letter under the notation "cc:".