

**MEDICAL ASSOCIATES HEALTH PLANS  
OPERATIONS POLICY AND PROCEDURES MANUAL**

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<b>POLICY NUMBER:</b>	10 & 10A <sup>1</sup>
<b>POLICY TITLE:</b>	Internal Appeal of an Adverse Benefit Determination – Commercial Members (Iowa and Illinois)
<b>POLICY STATEMENT:</b>	To assure a timely, efficient and consistent process for responding to an internal appeal of an Adverse Benefit Determination for members covered by a Large Group or Small Group Subscriber Agreement.

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**Introduction**

This Policy/Procedure governs appeals of an Adverse Benefit Determination only. For other complaints or grievances (i.e., expressions of discontent), such as about the quality of health services provided to a member or service provided by MAHP, see MAHP Administrative Policy, Complaint Resolution.

Federal law provides that an individual is entitled to one “Full and Fair Review” of an “Adverse Benefit Determination.” This full and fair review includes the right to an internal appeal. This Policy/Procedure sets forth the procedures and guidelines for an internal appeal by Members of commercial plans in Iowa and Illinois.

If the outcome of the internal appeal is a “Final Adverse Benefit Determination”, and that final decision is based on a matter of medical or clinical judgment (such as medical necessity, appropriateness, health care setting, level of care or effectiveness, investigative/experimental), the individual has the right to request an external review. For procedures related to a request for external review, see MAHP Operations Policy 10-1/10A-1, External Review of an Adverse Benefit Determination (Iowa and Illinois).

MAHP is required to provide all notifications to Members related to appeals in a cultural and linguistic appropriate manner.<sup>2</sup> For appeals of a Concurrent Care Claim, members are allowed to have continued coverage under their medical benefit pending the outcome of the appeal.

**Summary of Procedure**

1. Determine if the issue raised by the Member is an appeal of an “Adverse Benefit Determination”, as defined in Section II below. A Member’s right to an internal appeal is not triggered unless MAHP has issued an Adverse Benefit Determination  
*If yes, proceed to #2.*  
*If no, refer to MAHP Administrative Policy 9, Complaint Resolution.*
2. Determine if the appeal involves a medical or clinical judgment.  
*If yes, the appeal should be referred to **Health Care Services**.*  
*If no, the appeal relates to an administrative matter and should be referred to **Member Services**.*

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<sup>1</sup> Operations Policies 10 (Iowa internal appeal procedures) and 10A (Illinois internal appeal procedures) are merged in this document for ease of use and reference by staff.

<sup>2</sup> According to federal law under 29 CFR 2560.503-1(o), the plan must provide oral language services, including answering questions, as well as written notices (upon request), in any applicable non-English language. NCQA Guidelines (RR2) also require the availability of language interpretation services to help members through the appeal process.

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3. Determine if the appeal involves an Urgent Care Claim, as defined in Section II below.  
*If yes, follow the procedures for **Expedited Internal Appeal** in Section IV(A), below.*  
*If no, follow the procedures for **Standard Internal Appeal** in Section IV(B), below.*

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**I. Definitions.**

**Adverse Benefit Determination.** An “Adverse Benefit Determination” is generally defined by law as a decision that denies, in whole or in part, a claim for benefits under a group health plan. The claim for benefits may be a pre-service claim, post-service claim, or concurrent care claim.

An Adverse Benefit Determination includes any decision by MAHP that is a denial, reduction, termination of, or refusal to provide or pay for a benefit – such as for an admission, continued stay, level of care, or health care service/treatment/drug or other item – based on any of the following:

- The individual is not eligible to participate in the plan;
- The benefit is not covered under the plan
- Services were received from a provider that is not in the network;
- The benefit is not medically necessary or appropriate;
- The benefit is experimental or investigational;
- The health care setting or level of care is not appropriate;
- Application of any utilization review; or
- A decision to rescind coverage (i.e., retroactive cancellation, such as due to a fraudulent representation in an application)<sup>3</sup>

**Concurrent Care Claim.** A “Concurrent Care Claim” is a claim for a benefit during a patient’s stay or course of treatment in a facility or other inpatient or outpatient health care setting (IL law in 215 ILCS 180/10

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<sup>3</sup> This does not include rescinded coverage for failure to pay premiums (see 50 Ill Admin. Code 4530.30)

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Final Adverse Benefit Determination. A “Final Adverse Benefit Determination” is an Adverse Benefit Determination that is upheld at the conclusion of the internal appeal process.

Pre-Service Claim. A “Pre-Service Claim” is any claim for a benefit that is conditioned, in whole or in part, on approval in advance of obtaining medical care.

Post-Service Claim. A “Post-Service Claim” is any claim for a benefit that is not a pre-service claim – i.e., care has already been received.

Urgent Care Claim. An “Urgent Care Claim” is any claim for medical care or treatment if application of the time periods for a non-urgent determination:

- Could **seriously jeopardize the life or health** of the Member or the ability of the Member to **regain maximum function**; or
- In the opinion of a physician with knowledge of the Member’s medical condition, would subject the Member to **severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim** for benefits.
- *(Added by IL law only):* An urgent care claim also includes: (i) for a Member with an ongoing course of treatment, a claim for a service or treatment which, if denied, would significantly increase the risk to a Member’s health; or (ii) a treatment referral, service, or treatment if the denial could **significantly increase the risk to the member’s health**<sup>4</sup>

Whether a claim involves “urgent care” is determined by the attending provider, and MAHP must defer to this determination.

**II. Authorized Representative.** MAHP is required to allow an “Authorized Representative”<sup>5</sup> to act on behalf of a Member in an appeal of an Adverse Benefit Determination. The Member is permitted to act through an Authorized Representative at any stage in the internal appeal process. Once a Member has designed an Authorized Representative, all communications should be to the Authorized Representative, with a copy to the Member.

- Non-Urgent Care Appeals – Form Required. Except for Urgent Care Claims, a Member is generally required to fill out and return a written appointment form before MAHP will consider the individual the Member’s Authorized Representative. The form is available at: <H:\Appeals\Appointment of Authorized Personal Representative Form> (and is also attached as Exhibit F to this Policy).

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<sup>4</sup> See 215 ILCS 134/45

<sup>5</sup> Illinois law specifically identifies persons that can be authorized representatives, including any person (i) who has received “express consent” from the member (i.e., through an authorization form); (ii) authorized by law (i.e., through a guardianship or power of attorney); a family member or health care provider “when the covered person is unable to provide consent”; (iv) for urgent requests, a health care provider with knowledge of the member’s medical condition. See 215 ILCS 180/10.

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- Urgent Care Appeals. For appeals of an Urgent Care Claim, completion of the Authorized Representative form is not required. An Authorized Representative may be a health care professional with knowledge of the member’s medical condition.<sup>6</sup>

**III. Applicable Timeframes.**

180 Days to Appeal. A Member has 180 days from receipt of notification of an initial Adverse Benefit Determination to file an internal appeal.

MAHP Response. Upon receipt of an internal appeal, MAHP’s time period to respond depends on whether the appeal is an **Expedited Internal Appeal**<sup>7</sup> (i.e., for Urgent Care Claims) or a **Standard Internal Appeal**. For standard internal appeals, if the Member has failed to provide information necessary to process an appeal, ERISA procedures permit MAHP to notify the Member that an extension is necessary. The time period for deciding the appeal is tolled from the date on which the notification is sent until the date on which the Member responds to the request for additional information.

<b>Expedited Internal Appeals<sup>8</sup></b>	
<b>Illinois</b>	
Timeframe for notification of information needed to evaluate an appeal	Within <b>24 hours</b> of receipt
Timeframe for decision on appeal	Within <b>24 hours</b> of receipt of required information <i>(*If a decision is not reached <b>within 48 hours</b>, the member has the right to file a request for external review)</i>
<b>Iowa</b>	
Timeframe for decision on appeal	As soon as possible, but no later than <b>72 hours</b> after review is commenced (unless a delay is agreed to)

<sup>6</sup> See 29 CFR 2560.503-1(b)(4); 215 ILCS 180/10. Federal law states that a plan may establish “reasonable procedures for determining whether an individual has been authorized to act on behalf of a claimant; provided that, in the case of a claim involving urgent care, . . . a health care professional . . . with knowledge of a claimant’s medical condition shall be permitted to act as the authorized representative of a claimant.”

<sup>7</sup> Note that the timelines set forth in federal law will apply unless the law of the Member’s state provides greater rights and protections. Illinois is a state that provides greater protections as to the timelines for response to an appeal.

<sup>8</sup> Applicable only to pre-service claim denials. By definition, a post-service claim cannot be an urgent care situation. (See Benefit Claims Procedure Regulation FAQs, at <https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/benefit-claims-procedure-regulation>)

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<b>Standard Internal Appeals</b>	
<b>Illinois</b>	
For Appeals of both Pre-Service & Post-Service denials:	
Notification from MAHP of information needed to evaluate an appeal	Within <b>3 <u>business</u> days</b> of request for review
Timeframe for decision on appeal	Within <b>15 <u>business</u> days</b> after receipt of required information
<b>Iowa</b>	
MAHP decision on appeal of Pre-Service denial	<b>30 days</b> after receipt of appeal
MAHP decision on appeal of post-service denial	<b>60 days</b> after receipt of appeal

<b>NCQA Standards (UM 8)</b>	
Expedited Appeal	Within <b>72 hours</b> of receipt of appeal
Standard (non-urgent) Pre-Service appeal	Within <b>30 days</b> of receipt of appeal
Post-Service appeal	Within <b>60 days</b> of receipt of appeal

**IV. Internal Appeal Procedures.**

Upon receipt of the appeal, MAHP will appoint an individual to conduct the review. The appeal will be reviewed once.

If the appeal involves a **medical or clinical determination**, the review will be referred to the Health Care Services Department. Medical or clinical matters include decisions relating to medical necessity, appropriateness, health care setting, level of care or effectiveness, and investigative/experimental treatment.

If the appeal involves **administrative** matters, the appeal will be reviewed by the Manager of Member Services. Examples of administrative matters include the following: an individual is not eligible to participate in the plan; the appeal is not timely; the service or supply requested or received is not covered; or services were received from a provider that is not in the network.

The appeal shall be conducted in accordance with federal law regarding a Full and Fair Review<sup>9</sup> and the laws of the state of the appeal.

The reviewer may not be the original adverse decision maker or a subordinate of the original decision maker. The review may not afford deference to the initial determination. At any time during the appeal process, the Member has the right to be represented by someone of his/her choosing.

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<sup>9</sup> These rules are outlined in Section VI of this document.

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If upon review of a claim, new information is considered or generated, or a new or additional rationale is relied on for a denial, this information must be provided to the Plan Participant as soon as possible, free of charge, and automatically – not just if requested. The Plan Participant must be given a reasonable opportunity to respond before a Final Adverse Benefit Determination.

Depending on whether the appeal is an Expedited Internal Appeal or a Standard Internal Appeal, the following procedures will apply:

**A. Expedited Internal Appeal:**

An expedited internal appeal may be filed if the requirements for an Urgent Care Claim (see Definitions, above) are met. This appeal may be submitted **verbally or in writing**.

To file a request verbally, the Member or his/her representative may contact Health Care Services directly. This appeal also may be submitted by a health care provider with knowledge of the Member's condition, even if the form for an Authorized Representative has not been completed.

The Health Care Services Department will document receipt of the appeal, the substance of the appeal, and the actions taken. HCS also will investigate all aspects of clinical care involved, as applicable.

All necessary information related to the appeal should be transmitted as expeditiously as possible. The member may submit written comments, documents, records or other information in support of the appeal. The member can request access to and copies of all documents relevant to the member's appeal.

Information pertaining to an expedited internal appeal may be requested in writing or via phone and can include part or all of the medical records, a statement from the attending practitioner, and information obtained by MAHP. If an expedited appeal involves a concurrent review determination, the service must be continued without liability to the member until the member is notified of the decision, unless it is related to an admission that was not previously authorized.

The appeal will be reviewed by an appropriate medical professional in the same or similar specialty that typically treats the medical condition, performs the procedures, or provides the treatment.

A decision on the appeal will be made as soon as possible, and within the timeframes set forth in the table in Section III, above. If the decision is provided orally, written confirmation will follow, and will include the information set forth in Section IV, below.

**B. Standard Internal Appeal:**

A standard internal appeal must be filed in writing. The written request may be hand delivered, emailed, faxed or mailed to MAHP. A member may utilize the MAHP Appeal Form. This form is located at <H:\Appeals\Appeal Form> (and is attached as Exhibit G to this Policy).

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The written request will be date stamped upon receipt by MAHP. The following information should be obtained and recorded at H:\Appeals\ ( i.e. 2021 Appeals.xlsx):

- member name
- member number
- state
- employer group
- group number
- authorization number, if applicable
- date received
- name of individual filing appeal

The member may submit written comments, documents, records or other information in support of the appeal. The member can request access to and copies of all documents relevant to the member’s appeal. (See Section V, below, regarding documents and information a Member is entitled to receive upon request.) The materials must be provided to the Member free of charge.

For appeals related to medical or clinical matters, the appeal will be reviewed by an appropriate medical professional in the same or similar specialty that typically treats the medical condition, performs the procedures, or provides the treatment.

If new or additional evidence is considered, relied on, or generated in connection with the appeal, this information will be provided to the Member as soon as possible, and sufficiently in advance of a Final Adverse Benefit Determination to allow the Member a reasonable opportunity to respond prior to the final internal decision.

The member also has the right to file a complaint with the applicable state insurance commissioner’s office. The member, if living in a state different than his/her place of employment, should contact the insurance division where his/her employer group is based. The address and phone number of the insurance commissioner’s office is provided to members in their Subscriber Agreement and will be provided in any Final Adverse Benefit Determination. Contact details for insurance commissioner offices for Iowa and Illinois are:

<p>Iowa Insurance Division 601 Locust St. Fourth Floor Des Moines, IA 50309-3738 (515) 281-5705 Website <a href="http://www.iid.iowa.gov">www.iid.iowa.gov</a></p>	<p>Illinois Department of Insurance 320 West Washington St, 4th Floor Springfield, IL 62767 (877) 527-9431 Fax: (217) 557-8495 Email: <a href="mailto:doi.externalreview@illinois.gov">doi.externalreview@illinois.gov</a> Website: <a href="https://mc.insurance.illinois.gov/messagecenter.nsf">https://mc.insurance.illinois.gov/messagecenter.nsf</a></p>
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**V. Content of a Final Adverse Benefit Determination.<sup>10</sup>**

If the initial Adverse Benefit Determination is upheld at the conclusion of the internal appeal, the letter documenting the Final Adverse Benefit Determination will be sent via certified mail to the Member or Member's Authorized Representative by the MAHP Department that reviewed the appeal. Sample letters are included in the Attachments to this document.

Information to be included in a Final Adverse Benefit Determination includes:

**A. Federal Law Requirements – All Adverse Benefit Determinations:**

- Sufficient information to identify the details of the claim (date of service, health care provider, and claim amount, if any);
- Details of the claim and a statement that the diagnosis or treatment codes (and descriptions/ corresponding meaning) are available on request;
- The specific reason or reasons for the decision, including any denial code and its meaning;
- Reference to the specific plan provision, guideline, protocol, standard or criterion on which the decision is based, and notice that the actual benefit provision, guideline, protocol or criterion is available on request;
- A statement that the claimant is entitled to receive, on request and free of charge, access to or copies of all documents, records, and other information “relevant” to the claim for benefits (A document is “relevant if it was relied on in making the benefit determination, or was submitted, considered or generated in the course of the benefit determination);
- A statement of the evidence, clinical rationale, or documentation relied on;
- A description of the external review process, including information regarding how to initiate external review;
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist with external review; and
- A statement of the claimant's right to bring an action under section 502(a) of ERISA. A statement that “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.”

**B. Illinois – Additional Details for Final Adverse Benefit Determination on Medical/ Clinical Matters:**

Illinois requires that additional information be included in any Final Adverse Benefit Determination for an Illinois-based employer group that is based on medical judgment or a medical determination, including: (i) a determination by the plan that an admission, availability of care, continued stay, or other health care service does not meet the plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness; (ii) that a treatment is experimental or investigative; (iii) that

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<sup>10</sup> See 29 CFR 52560.503-1(j)

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there is no coverage due to a pre-existing condition; or (iv) coverage was rescinded for a reason other than failure to pay premium or cost-share in a timely fashion. In these situations, the notification shall also include the following:

- the name, address, toll-free phone number, fax number, and email address of the administrator that handles appeals;
- a statement that there is one level of internal appeal under the plan;
- the date (day, month & year) of the initial Adverse Benefit Determination and the Final Adverse Benefit Determination;
- a notification that the deadlines for filing an external review are not postponed or delayed by health care provider appeals unless the health care provider is the member's authorized representative;
- a statement that the decision is the Final Adverse Determination, that all internal appeals have been exhausted; and that the member has 4 months from the date of the letter to file a request for external review;
- a statement substantially equivalent to: "We have denied your request for the provision of or payment for a health care service or course of treatment. You may have a right to have our decision reviewed by health care professionals who have no association with us by submitting a written request for external review to the Department of Insurance, Office of Consumer Health Information, 320 West Washington Street, 4<sup>th</sup> Floor, Springfield, Illinois, 62767."
- a description of the procedures for standard and expedited external review;
- notification of the availability of expedited external review if the issue involves (i) an urgent care claim; (ii) care for which the member received emergency services and the member has not been discharged from a facility; or (iii) if the denial is because a service is experimental or investigational, and the treating health care professional certifies in writing the treatment would be significantly less effective if not promptly initiated;
- a statement that an expedited or standard external review request deemed to be ineligible for review by the plan may be appealed to the Illinois Insurance Director, using the contact information set forth in Section III, above;
- The Final Adverse Benefit Determination must include a copy of the description of both the standard and expedited external review procedures, highlighting in the description the procedures giving the member the opportunity to submit additional information; and
- The Final Adverse Benefit Determination must include the following forms, **which are available on the Illinois Department of Insurance website, at <https://insurance2.illinois.gov/ExternalReview/ExternalReviewMain.html>**
  - Illinois External Review Request form,
  - the IL Authorized Representative Form, and
  - the IL Health Care Provider Certification form for expedited and experimental requests

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**C. Iowa – Additional Details for Adverse Benefit Determination on Medical/Clinical Matters:**

Iowa requires that additional information be included in any Final Adverse Benefit Determination for an Iowa-based employer group that is based on medical judgment or a medical determination, including: (i) a determination by the plan that an admission, availability of care, continued stay, or other health care service does not meet the plan’s requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness; or (ii) that a treatment is experimental or investigative. In these situations, the notification shall also include the following:

- A statement substantially equivalent to: “We have denied your request for the provision of or payment for a health care service or course of treatment. You may have the right to have our decision reviewed by health care professionals who have no association with us if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service or treatment you requested by submitting a request for external review to the commissioner of insurance”;
- the current address and contact information for the Iowa Insurance Commissioner;
- notification of the availability of expedited external review if the issue involves (i) an urgent care claim; (ii) care for which the member received emergency services and the member has not been discharged from a facility; or (iii) if the denial is because a service is experimental or investigational, and the treating health care professional certifies in writing the treatment would be significantly less effective if not promptly initiated;
- a copy of the descriptions of the standard and expedited external review procedures, as well as any form used, and highlighting in the description the procedures that give the member the opportunity to submit additional information;
- an authorization form or other form as required by the DOI for disclosure of PHI, including medical records, that are pertinent to the external review

**VI. Federal Requirements for a “Full and Fair Review”.**

Federal law provides that an individual is entitled to one “full and fair” review of an Adverse Benefit Determination. To ensure a full and fair review, the following are required in an internal appeal:

1. Member’s Right to Submit Written Materials. The Member must have the opportunity to submit written comments, documents, records, and other information related to the claim for benefits.
2. Member’s Right to Receive Documents. The member must be provided, *upon request and free of charge*, copies of all documents, records, and other information “relevant” to the claim for benefits. Documents, records and other information are “relevant” if they were:
  - relied on in making the initial benefit determination; or
  - were submitted, considered or generated in the course of the initial benefit determination, even if they were not specifically relied on.
  - a statement of policy or guidance with respect to the plan that concerns a denied treatment or benefit for the member’s diagnosis (even if the policy or statement was not relied on in making the adverse determination)

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3. Review of Information Submitted by Member. The internal review must take into account all comments, documents, records and other information submitted by the Member, even if the information was not submitted or considered in the initial review of the claim for benefits.
4. Impartial Reviewer. The internal review must be conducted by someone who was not the individual who made the initial benefit determination or a subordinate of that individual. The individual reviewing the appeal must be independent and impartial, and employment decisions with respect to the reviewer may not be based on the outcome of any appeals.
5. Medical Professional Review. If the internal review involves medical judgment (such as whether a treatment, drug or item is medically necessary, appropriate experimental or investigational), a “health care professional” must be consulted who has appropriate training and experience in the field of medicine involved. This health care professional must not have been consulted in the initial benefit determination or be a subordinate of anyone consulted in the initial benefit determination. This health care professional must be “licensed, accredited or certified” under state law.
6. New Evidence on Appeal. If new or additional evidence is considered, relied on, or generated in connection with the appeal, this information must be provided to the Member as soon as possible (and sufficiently in advance of a Final Adverse Benefit Determination) to allow the Member a reasonable opportunity to respond prior to the final internal decision.
7. New Rationale for Denial. If a final internal decision on an appeal will be based on a new or additional rationale, the Member must be provided, free of charge, with the rationale with enough time to allow the Member to have a reasonable opportunity to respond. If the time period for issuing the Final Adverse Benefit Determination is about to expire, then that time period is tolled to allow the Member a reasonable opportunity to respond.
8. Content of Final Adverse Benefit Determination. Any decision that is a Final Adverse Benefit Determination must include the following information:
  - Sufficient information to identify the details of the claim (date of service, health care provider, and claim amount, if any)
  - A statement describing the availability, upon request, of any diagnosis code or treatment code, with the corresponding meaning)
  - If there is a denial code, the meaning of code, as well as the plan’s standard that was used in denying the claim and a discussion of the decision
  - A description of the available external review process, including information regarding how to initiate it; and
  - The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist with external review

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**VII. Conclusion of the Appeal – Tracking & Audit Procedures.**

When the appeal process is complete, the department responsible for the appeal (HCS or Member Services) will document the information in the current year’s appeal Excel spreadsheet located @ H:\Appeals\ ( i.e. **2021 Appeals.xlsx**) (see MAHP Administrative Policy, Appeal/Grievance Tracking Procedures).

NOTE: This policy and procedure identifies MAHP’s internal appeal procedure. If there is a conflict between this procedure and a Member Subscriber Agreement, the terms of the Subscriber Agreement will override this document.

NOTE: This policy and procedure is not used for Health Choices. There is a separate process for this product.

**VII. Citations to Applicable Law.**

<b>Federal</b>	<b>Iowa</b>	<b>Illinois</b>
29 CFR § 2560.503-1 (ERISA Claims procedure)	Iowa Code Chapter 514J (External Review of Health Care Coverage Decisions)	215 ILCS 134/45 (appeals, complaints, and external reviews), Managed Care & Reform and Patient Rights Act (MCRPRA)
29 CFR § 2590.715-2719 (ACA - Internal claims and appeals and external review processes)	Iowa Admin Code Chapter 76 (External Review)	215 ILCS 134/10 (Definitions) MCRPRA
		215 ILCS 180 (Health Carrier External Review Act)
		215 ILCS 180/20 (Notices must include language informing of right to external review)
		50 Ill. Admin. Code Part 4530 (Health Carrier External Review)

**VIII. Attachments.**

- A. Final Adverse Benefit Determination (Appeal Upheld) – Iowa
- B. Notice of Appeal Rights – External Review (for Iowa Denials on Medical Matters) & External Review Request Form
- C. Final Adverse Benefit Determination (Appeal Upheld) – Illinois  
IDOI Fact Sheet – External Review & Illinois Department of Insurance – Request for External Review
- D. Internal Appeal Decision – Reversal
- E. Request for Additional Information.
- F. Appointment of Authorized Representative Form
- G. Appeal Form

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Barb Koerperich, MSN  
Director of Quality and Health Care Services

\_\_\_\_\_  
Date

\_\_\_\_\_  
Karen Hoffmann  
Director of Operations

\_\_\_\_\_  
Date

Original Effective Date: 06/95  
Revised Date(s): 02/96, 02/97, 08/97, 08/98, 01/99, 04/99, 08/99, 10/99, 04/00, 04/01, 07/01, 01/02, 02/02, 05/02, 06/02, 12/02, 02/03, 11/03, 12/03, 04/04, 09/04, 01/05, 03/05, 05/06, 02/07, 01/08, 05/08, 11/09, 11/10, 05/11, 07/12, 04/13, 04/14, 05/15, 05/16, 05/17, 5/18, 4/19, 12/20, 2/21

**REQUIRED DISTRIBUTION LIST**

- |  |  |   |
|--|--|---|
| <input checked="" type="checkbox"/> Administration | <input type="checkbox"/> EDI                             | <input checked="" type="checkbox"/> Member Services |
| <input checked="" type="checkbox"/> Claims         | <input type="checkbox"/> Facilities                      | <input type="checkbox"/> Provider Relations         |
| <input type="checkbox"/> Commercial Sales          | <input checked="" type="checkbox"/> Finance              | <input type="checkbox"/> Physicians/Practitioners   |
| <input checked="" type="checkbox"/> Compliance     | <input checked="" type="checkbox"/> Health Care Services | <input checked="" type="checkbox"/> Pharmacy        |
| <input type="checkbox"/> Configuration             | <input type="checkbox"/> Marketing                       | <input type="checkbox"/> Quality Improvement        |
| <input type="checkbox"/> Credentialing             | <input type="checkbox"/> Medicare Sales                  |   |

**Attachment A: Final Adverse Benefit Determination - Iowa**

Date

SENT VIA CERTIFIED MAIL

Name of Subscriber/Authorized Representative  
Address  
City/State/Zip

Member Name:	Claim Number(s):
Member Number:	Claim Amount:
Date of Service:	Provider Name:
Date of Receipt of Appeal:	

Dear Ms./Mr. \_\_\_\_\_:

This letter is in response to your appeal of an adverse benefit determination for the above-referenced claim. Medical Associates Health Plans (MAHP) takes all appeals seriously and is committed to a thorough and timely response. As a Member entitled to benefits under the [Group Name] Subscriber Agreement, your appeal is important, and I have conducted an investigation into this claim.

The Claim

Our records indicate that this appeal relates to a claim for... *[insert details of claim]*

*[Discuss and include all pertinent information related to the appeal and circumstances surrounding the claim. Include as much information as is necessary, and reference documents and records as appropriate.]*

The Subscriber Agreement

According to our records, you are a member entitled to benefits under the [INSERT EMPLOYER] health plan, which is an [Iowa/Illinois] [Year] [Large/Small] Group plan. In researching this appeal, I have reviewed the terms of the [INSERT EMPLOYER] Subscriber Agreement, including Article [Number], [Title], [SUCH AS Article 4, Covered Services, and Article 5, Exclusions]. Article [Number], [Title], states as follows:

*[Quote language directly, indenting from each margin. Underline/bold relevant language as necessary.]*

See Subscriber Agreement, page(s) [redacted] (emphasis added).

Decision on Appeal

An individual is entitled to one full and fair review of an adverse benefit determination that denies, in whole or in part, a claim for benefits under a group health plan. In reviewing your appeal of the denial of the

above-referenced claim, the documents and records discussed above have been examined, as well as all information submitted in conjunction with your [*letter of appeal/appeal request*], dated [*Date*].

Upon review, the denial of the above-referenced claim is upheld. Benefits will not be paid for this claim. This determination is based on [*discuss rationale*]

*[For appeals related to medical/clinical matters, such as medical necessity, any guideline, protocol, standard or criterion relied on must be identified. There also must be a statement that the actual guideline, protocol or criterion is available on request.*

*In addition, all evidence, clinical rationale, or documentation relied on to deny the claim also must be identified and/or explained.]*

*[Conclusion – for Appeals of Non-Medical Matters:]*

Please note that this decision constitutes a final adverse benefit determination. The right to an internal appeal has been exhausted. Should you require a description of any diagnosis or treatment code, this information is available upon request. There also may be other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S. Department of Labor Office or State insurance regulatory agency. The Iowa Insurance Division may be reached at 601 Locust St., Fourth Floor, Des Moines, IA 50309-3738; at (515) 281-5705; or at [www.iid.iowa.gov](http://www.iid.iowa.gov). You also may have a right to bring an action under ERISA Section 502(a).

We understand that navigating the insurance process can be difficult. We appreciate the opportunity to explain our position on this appeal. If we may be of any further assistance, please contact the MAHP Member Services Department at 563-584-4885 or 1-866-821-1365 (toll free), or by email at [memberservices@mahealthcare.com](mailto:memberservices@mahealthcare.com).

*[Conclusion – for Appeals Based on Medical/Clinical Matters:]*

Please note that this decision constitutes a final adverse benefit determination. The right to an internal appeal has been exhausted. Should you require a description of any diagnosis or treatment code, this information is available upon request.

You may have a right to have our decision reviewed by health care professionals who have no association with us by submitting a written request for external review. Your request must be filed within four (4) months from the date of this final adverse benefit determination. Your request must be submitted to the Department of Insurance at: Iowa Insurance Division, 601 Locust St., Fourth Floor, Des Moines, IA 50309-3738. The Iowa Department of Insurance may also be reached at (515) 281-5705, or online at [www.iid.iowa.gov](http://www.iid.iowa.gov).

You also may have the right to expedited external review under certain medically-urgent circumstances. More information regarding standard external review procedures and expedited external review procedures are included with this letter.

There also may be other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S. Department of Labor Office or State insurance regulatory agency. You also may have a right to bring an action under ERISA Section 502(a).

We understand that navigating the insurance process can be difficult. We appreciate the opportunity to explain our position on this appeal. If we may be of any further assistance, please contact the MAHP Member Services Department by phone at 563-584-4885 or 1-866-821-1365 (toll free), or by email at [memberservices@mahealthcare.com](mailto:memberservices@mahealthcare.com).

Sincerely,

Name  
Title  
Medical Associates Health Plans

cc: Member *[include only if letter is to an Authorized Representative]*

Enclosures: *[include only if appeal is upheld based on Medical/Clinical Matters]*  
Notice of Appeal Rights – External Review  
External Review Request Form

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-821-1365 (TTY: 1-800-735-2942).

## Attachment B (Iowa)

To Be Included With Every Final Adverse Benefit Determination based on Medical/Clinical Judgment

### NOTICE OF APPEAL RIGHTS – EXTERNAL REVIEW

**External Review:** We have denied your request for the provision of or payment for a health care service or course of treatment. If our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested, you may have a right to have our decision reviewed by health care professionals who have no association with us. Request for external review may be submitted to the Commissioner of Insurance.

You may obtain an external review if:

- Our decision involved the admission, availability of care, continued stay, or other health care service that is a covered benefit; and
- We denied, reduced or terminated the requested service or treatment or payment for the service or treatment because we determined it did not meet our requirements for medical necessity, health care setting, level of care or effectiveness of the healthcare service or treatment you requested.
- You have a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function. In this situation, you may file a request for an **expedited external review** of our denial.
- The final adverse determination concerns an admission, availability of care, continued stay, or a health care service for which you received emergency services, but you have not been discharged from a facility. In this situation, you or your authorized representative may request an **expedited external review**.
- Our denial to provide or pay for health care service or course of treatment is based on a determination that the service or treatment is experimental or investigational. In addition, if your treating health care professional certifies in writing that the recommended or requested health care service or treatment that is the subject of the recommendation or request would be significantly less effective if not promptly initiated, then you or your authorized representative may request an **expedited external review**.

You can obtain a copy of the External Review Request Form from: the Iowa Insurance Division, Two Ruan Center, 601 Locus, Fourth Floor, Des Moines, Iowa 50309; telephone 877-955-1212 or 515-281-6348; facsimile 515-281-3059; Website [www.iid.iowa.gov](http://www.iid.iowa.gov).

Within **four months** after receipt of our notice containing the final adverse determination and this Notice of Appeal Rights, you should submit a request for external review to the Iowa Insurance Division, Two Ruan Center, 601 Locust, Fourth Floor, Des Moines, Iowa 50309; telephone 877-955-1212 or 515-281-6348; facsimile 515-281-3059; email [iid.marketregulation@iid.iowa.gov](mailto:iid.marketregulation@iid.iowa.gov).

For standard external review, a decision will be made within 45 days after the independent review organization receives your request.

For details, please review your Subscriber Agreement, contact us, or contact the Iowa Insurance Division.

## EXTERNAL REVIEW REQUEST FORM

### SECTION 1. ELIGIBILITY FOR EXTERNAL REVIEW

This External Review Request Form must be filed with the Iowa Insurance Division within **four months** after your health carrier denied, reduced or terminated the requested health care service or treatment or payment for the service or treatment. You or your authorized representative may request an external review under any of the following circumstances:

1. Your health carrier has made a determination that an admission, availability of care, continued stay, or other health care service that is a covered benefit does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated. **Please follow the directions in Sections 1 and 2, then submit completed Sections 3 and 4, Section 5 if applicable, and Section 7 if you are requesting an expedited review.**
2. Your health carrier has made a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational. **Please follow the directions in Sections 1 and 2, then submit completed Sections 3 and 4, Section 5 if applicable, Section 6, and Section 7 if you are requesting an expedited review.**
3. The final adverse determination concerns an admission, availability of care, continued stay, or a health care service for which you received emergency services, but you have not been discharged from a facility. **Please follow the directions in Sections 1 and 2, then submit completed Sections 3 and 4, Section 5 if applicable, and Section 7.**

If coverage was denied for a service or treatment specifically listed in your health insurance policy as excluded from coverage (other than what is listed in paragraphs 1 and 2 above), you will not be eligible for external review.

You also will need to have completed any internal appeals with your health carrier before you can request an external review, unless:

1. You already did request an internal appeal with your health carrier and have not received a decision and it has been 30 days since you requested the appeal; or
2. Your health carrier has waived the requirement that you complete an internal appeal before requesting an external review; or
3. You need an expedited review because time is a factor in your treatment.

### SECTION 2. WHAT TO SEND AND WHERE TO SEND IT YOU MUST SUBMIT ITEMS 1 AND 2 BELOW:

1. This External Review Request Form, signed and dated, with the sections completed for your particular situation as described in Section 1. If you would like help completing your external review request for submission, contact the Market Regulation Bureau of the Iowa Insurance Division by calling 515-281-6348, or by e-mail at [iid.marketregulation@iid.iowa.gov](mailto:iid.marketregulation@iid.iowa.gov).

2. One of the following:
- a. The letter from the covered person's health carrier or utilization review company that states that the decision is final and that the covered person or the covered person's authorized representative has exhausted all internal appeal procedures;
  - b. The letter from the covered person's health carrier or utilization review company that states it has waived the requirement to exhaust all of the health carrier's internal appeal procedures;
  - c. A copy of the covered person's or the covered person's authorized representative's request for internal appeal and a statement that no decision from the health carrier has been received for 30 days; or
  - d. A completed request for expedited review, Section 7 of this form.

**WHERE TO SEND IT:**

If you are requesting a standard external review, send all paperwork to the Iowa Insurance Division, Two Ruan Center, 601 Locust, Fourth Floor, Des Moines, Iowa 50309; facsimile 515-281-3059; e-mail [iid.marketregulation@iid.iowa.gov](mailto:iid.marketregulation@iid.iowa.gov). If you have questions, telephone 877-955-1212 or 515-281-6348.

**If you are requesting an expedited external review**, call the Iowa Insurance Division (telephone 877-955-1212 or 515-281-6348) before sending your paperwork, and you will receive instructions on the quickest way to submit the application and supporting information.

**SECTION 3. INFORMATION REQUIRED FOR ALL EXTERNAL REVIEW REQUESTS**

**APPLICANT NAME**

The applicant is a:

- Covered Person/Patient
- Provider (the covered person/patient must complete Section 4)
- Authorized Representative (submit completed Sections 4 and 5)

**COVERED PERSON/PATIENT INFORMATION**

Covered Person's/Patient's Name:

Address:

Telephone Number:

Daytime:

Evening:

E-mail Address: Fax Number:

## **INSURANCE INFORMATION**

Name of Insurer or HMO:

Covered Person's Insurance ID Number and/or Policy Number:

Insurance Claim/Reference Number:

Insurer/HMO Mailing Address:

Insurer/HMO Telephone Number:

Insurer/HMO E-mail Address: Insurer/HMO Fax Number:

## **EMPLOYER INFORMATION**

Employer's Name:

Is the health coverage that you have through your employer a self-funded plan? (Y/N)\_\_\_\_\_.

Some self-funded plans may voluntarily provide external review, but may have different procedures. You should check with your employer.

## **HEALTH CARE PROVIDER INFORMATION**

Treating Physician/Health Care Provider:

Address:

Contact Person:

Telephone Number:

E-mail Address:

Fax Number:

Patient Medical Record Number:

## **REASON FOR HEALTH CARRIER'S DENIAL**

(Please check one.)

- The health care service or treatment was denied due to medical necessity, appropriateness, health care setting, level of care or effectiveness.
- The health care service or treatment is experimental or investigational (submit completed Section 6).
- Other: \_\_\_\_\_.

## **SUMMARY OF EXTERNAL REVIEW REQUEST**

Enter a brief description of the claim and the request for health care service or treatment that was denied and attach a copy of the denial from your health carrier.

## **HEALTH CARE SERVICE OR TREATMENT DECISION IN DISPUTE**

Describe in your own words the health care service or treatment decision in dispute and why you are appealing this denial. Indicate clearly the services being denied and the specific dates for the services being denied. Explain why

you disagree. Attach additional pages if necessary and include available pertinent medical records, any information you received from your health carrier concerning the denial, any pertinent peer literature or clinical studies, and any additional information from your physician or health care provider that you want the independent review organization to consider.

#### **SECTION 4. SIGNATURE AND RELEASE OF MEDICAL RECORDS**

To appeal your health carrier's denial, you must sign and date this external review request form and consent to the release of medical records.

I, \_\_\_\_\_, hereby request an external review. I attest that the information provided in this application is true and accurate to the best of my knowledge. I authorize my insurance company and my health care providers to release all relevant medical or treatment records to the independent review organization and the Iowa Insurance Division. I understand that the independent review organization and the Iowa Insurance Division will use this information to make a determination on my external review and that the information will be kept confidential and will not be released to anyone else. This release is valid for one year.

---

Signature of covered person/patient or legal representative (parent, guardian, conservator or other – please specify)

Date:

#### **SECTION 5. APPOINTMENT OF AUTHORIZED REPRESENTATIVE**

**(Fill out this section only if someone else will be representing you in this request for external review.)**

You can represent yourself, or you may ask another person, including your treating health care provider, to act as your authorized representative. You may revoke this authorization at any time.

I hereby authorize \_\_\_\_\_ to pursue my external review request on my behalf.

---

Signature of covered person/patient or legal representative (parent, guardian, conservator or other – please specify)

Date:

Address of Authorized Representative:

Authorized Representative's Telephone Number:

Daytime:

Evening:

Fax Number:

E-mail Address:

**SECTION 6. REQUEST FOR EXTERNAL REVIEW OF DENIALS BASED ON THE REASON THAT THE TREATMENT WAS EXPERIMENTAL OR INVESTIGATIONAL**

**PHYSICIAN CERTIFICATION: EXPERIMENTAL OR INVESTIGATIONAL DENIALS**

**(To Be Completed by Treating Physician)**

I hereby certify that I am the treating physician for \_\_\_\_\_ (covered person's/patient's name) and that I have requested the authorization for a drug, device, procedure or therapy denied for coverage due to the insurance carrier's determination that the proposed therapy is experimental and/or investigational. I understand that in order for the covered person/patient to obtain the right to an external review of this denial, as treating physician I must certify that the covered person's/patient's medical condition meets certain requirements:

**In my medical opinion as the insured's treating physician, I hereby certify to the following:**

(NOTE: Requirements 1 through 3 below must all apply for the covered person/patient to qualify for an external review.)

1. The covered person/patient has a condition that qualifies under one or more of the following descriptions.

(Please check all descriptions that apply.)

- Standard health care services or treatments have not been effective in improving the covered person's/patient's condition.
  - Standard health care services or treatments are not medically appropriate for the covered person/patient.
  - There is no available standard health care service or treatment covered by the health carrier that is more beneficial than the requested or recommended health care service or treatment.
2. The physician is a licensed, board-certified, or board-eligible physician qualified to practice in the area of medicine appropriate to treat the covered person's condition.
  3. Scientifically valid studies using accepted protocols demonstrate that the health care service or treatment recommended or that is the subject of the adverse determination or final adverse determination is likely to be more beneficial to the covered person/patient than any available standard health care services or treatments.

**Explain:**

Please provide a description of the recommended or requested health care service or treatment that is the subject of the denial. (Attach additional information as necessary.)

Physician's Signature \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Name (Please print.) \_\_\_\_\_

## SECTION 7. REQUEST FOR EXPEDITED EXTERNAL REVIEW

### CERTIFICATION OF TREATING HEALTH CARE PROVIDER FOR EXPEDITED EXTERNAL REVIEW REQUEST

**(To Be Completed by Treating Health Care Provider)**

#### **NOTE TO THE TREATING HEALTH CARE PROVIDER:**

The standard external review process can take up to 60 days from the date the patient's request for external review is received by the Iowa Insurance Division.

The independent review organization should complete an expedited external review within 72 hours.

This form is for the purpose of providing the certification necessary to trigger expedited review.

#### **CERTIFICATION**

I hereby certify that I am a treating health care provider for the patient, \_\_\_\_\_; and that one of the following is true: (Please check all that apply.)

- Adherence to the time frame for conducting a standard external review of the patient's appeal would, in my professional judgment, seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function.
- The recommended or requested health care service or treatment that is the subject of the external review request would be significantly less effective if not promptly initiated.
- The final adverse determination concerns an admission, availability of care, continued stay, or a health care service for which the patient received emergency services, but has not been discharged from a facility.

For this reason, the patient's appeal of the denial by the patient's health carrier of the requested health care service or course of treatment should be processed on an expedited basis.

Treating Health Care Provider's Signature \_\_\_\_\_ Date \_\_\_\_\_ Treating Health

Care Provider's Name (Please print.) \_\_\_\_\_

Provider's Mailing Address:

Telephone Number:

E-mail Address: Fax Number:

Licensure and Area of Clinical Specialty:

**Attachment C: Final Adverse Determination Letter -- Illinois**

Date

SENT VIA CERTIFIED MAIL

Name of Subscriber/Authorized Representative  
Address  
City/State/Zip

Member Name:	Claim Number(s):
Member Number:	Claim Amount:
Date of Service:	Provider Name:
Date of Receipt of Appeal:	

Dear Ms./Mr. \_\_\_\_\_:

This letter is in response to your appeal of an adverse benefit determination for the above-referenced claim. Medical Associates Health Plans (MAHP) takes all appeals seriously and is committed to a thorough and timely response. As a Member entitled to benefits under the \_\_\_\_\_ [Group Name] Subscriber Agreement, your appeal is important, and I have conducted an investigation into this claim.

The Claim

Our records indicate that this appeal relates to a claim for... *[insert details of claim]*

*[Discuss and include all pertinent information related to the appeal and circumstances surrounding the claim. Include as much information as is necessary, and reference documents and records as appropriate.]*

The Subscriber Agreement

According to our records, you are a member entitled to benefits under the [INSERT EMPLOYER] health plan, which is an Illinois [Year] [Large/Small] Group plan. In researching this appeal, I have reviewed the terms of the [INSERT EMPLOYER] Subscriber Agreement, including Article [Number], [Title], [SUCH AS Article 4, Covered Services, and Article 5, Exclusions]. Article [Number], [Title], states as follows:

*[Quote language directly, indenting from each margin. Underline/bold relevant language as necessary.]*

See Subscriber Agreement, page(s) \_\_\_\_\_ (emphasis added).

## Decision on Appeal

An individual is entitled to one full and fair review of an adverse benefit determination that denies, in whole or in part, a claim for benefits under a group health plan. In reviewing your appeal of the denial of the above-referenced claim, the documents and records discussed above have been examined, as well as all information submitted in conjunction with your [*letter of appeal/appeal request*], dated \_\_\_\_\_.

Upon review, the denial of the above-referenced claim is upheld. Benefits will not be paid for this claim. This determination is based on [*discuss rationale*]

*[For appeals related to medical/clinical matters, such as medical necessity, any guideline, protocol, standard or criterion relied on must be identified. There also must be a statement that the actual guideline, protocol or criterion is available on request.*

*[In addition, all evidence, clinical rationale, or documentation relied on to deny the claim also must be identified and/or explained.]*

### [Conclusion Option 1 – for Appeals of Non-Medical Matters:]

Please note that this decision constitutes a final adverse benefit determination. The right to an internal appeal has been exhausted. Should you require a description of any diagnosis or treatment code, this information is available on request. There also may be other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S. Department of Labor Office or State insurance regulatory agency. The Department of Insurance may be reached at: Illinois Department of Insurance, Office of Consumer Health Information, 320 West Washington Street, 4<sup>th</sup> Floor, Springfield, Illinois, 62767. You also may have a right to bring an action under ERISA Section 502(a).

We understand that navigating the insurance process can be difficult. We appreciate the opportunity to explain our position on this appeal. If we may be of any further assistance, please contact the MAHP Member Services Department at 563-584-4885 or 1-866-821-1365 (toll free), or by email at [memberservices@mahealthcare.com](mailto:memberservices@mahealthcare.com).

### [Conclusion Option 2 – for Appeals Based on Medical/Clinical Matters:]

Please note that this decision constitutes a final adverse benefit determination. The right to an internal appeal has been exhausted. Should you require a description of any diagnosis or treatment code, this information is available on request.

We have denied your request for the provision of or payment for a health care service or course of treatment. You have the right to have our decision reviewed by an independent review organization not associated with us by submitting a written request for external review to the Department of Insurance, Office of Consumer Health Information, 320 West Washington Street, 4<sup>th</sup> Floor, Springfield, Illinois, 62767. The Illinois Department of Insurance may also be reached at (877) 527-9431; by fax at (217) 557-8495; by email at [doi.externalreview@illinois.gov](mailto:doi.externalreview@illinois.gov); or online at <https://mc.insurance.illinois.gov/messagecenter.nsf>. Your request must be filed within four (4) months from the date of this final adverse benefit determination. More information regarding external review, including the necessary form to request external review, is enclosed with this letter.

You also may have the right to expedited external review under certain medically-urgent circumstances. Information regarding standard external review and expedited external review is also included with this letter.

There also may be other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S. Department of Labor Office or State insurance regulatory agency. You also may have a right to bring an action under ERISA Section 502(a).

We understand that navigating the insurance process can be difficult. We appreciate the opportunity to explain our position on this appeal. If we may be of any further assistance, please contact the MAHP Member Services Department by phone at 563-584-4885 or 1-866-821-1365 (toll free), or by email at [memberservices@mahealthcare.com](mailto:memberservices@mahealthcare.com).

Sincerely,

Name  
Title  
Medical Associates Health Plans

cc: Member *[include only if letter is to an Authorized Representative]*

Enclosures: *[include only if appeal is upheld based on Medical/Clinical Matters]*

IDOI Fact Sheet - External Review

Request for External Review

Physician Certification Expedited Review

Appointment of Authorized Representative Form

*[Note: these documents are available at*

<https://insurance2.illinois.gov/ExternalReview/ExternalReviewMain.html>*]*

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-821-1365 (TTY: 1-800-735-2942).



February 2020

### Note:

*This information was developed to provide consumers with general information and guidance about insurance coverage and laws. It is not intended to provide a formal, definitive description or interpretation of Department policy. For specific Department policy on any issue, regulated entities (insurance industry) and interested parties should contact the Department.*

---

### Illinois Law

The [Health Carrier External Review Act](#) provides standards for the establishment and maintenance of external review procedures to assure covered persons have the opportunity for an independent review of an adverse benefit determination or final adverse benefit determination.

### Commonly Asked Questions

#### Is my denial eligible for external review?

Denials that involve medical judgment, determination of experimental or investigational treatment, pre-existing conditions, or rescission of coverage for a reason other than non-payment of premium or contributions are eligible for external review. The above includes, but is not limited to, medical necessity, appropriateness, effectiveness of a benefit, level of care, healthcare setting, length of treatment.

#### Why should I request an external review?

When your health carrier denies medical care or treatment, they are required by law to provide a process to appeal the denial. If you complete your health carrier's internal appeal process and your request is still denied, you may be eligible for an external review. An external review is an independent medical review of a health carrier's decision conducted by an Independent Review Organization (IRO) that is approved by IDOI. In Illinois there is no cost to the consumer to file an external review.

### When can I file an external review?

You must file your external review within **4 months** of receipt of your final adverse benefit determination (denial) from the health carrier.

### What if my situation is urgent, or experimental or investigational?

Your health care provider will need to complete the applicable certification form and submit to IDOI. Internal appeal and external review rights are exhausted at the same time in expedited circumstances.

### What happens if I don't qualify?

The Department will notify you that your request for external review has been denied, and when appropriate, information on how to file a complaint with the Department will be provided. If the Department's complaint investigation determines that clinical judgment was utilized, you will be notified of your right to file an external review.

### Are all plans subject to the Illinois Health Carrier External Review Act?

Not all health plans fall under the jurisdiction of the IDOI. Health plans that may be referred to a separate entity may include the following:

- You are covered by a self-insured employer, union, church, or non-federal governmental plan. Refer to your benefit booklet for appeals process.
- You are covered by a group plan issued in another state;
- The coverage is through Medicare, Medicaid, Federal Employees Health Benefits Program; Tricare or other military coverage;
- The coverage is for a specified disease (for example, "Cancer only"); specified accident or accident only coverage, credit, dental, disability income, hospital indemnity, long-term care insurance, vision care, or other limited supplemental benefits.

## How to File an External Review

IDOI accepts external review requests: **Send only copies. Keep your originals.**

Online through [IDOI Message Center](#)

Email at [DOI.externalreview@illinois.gov](mailto:DOI.externalreview@illinois.gov)

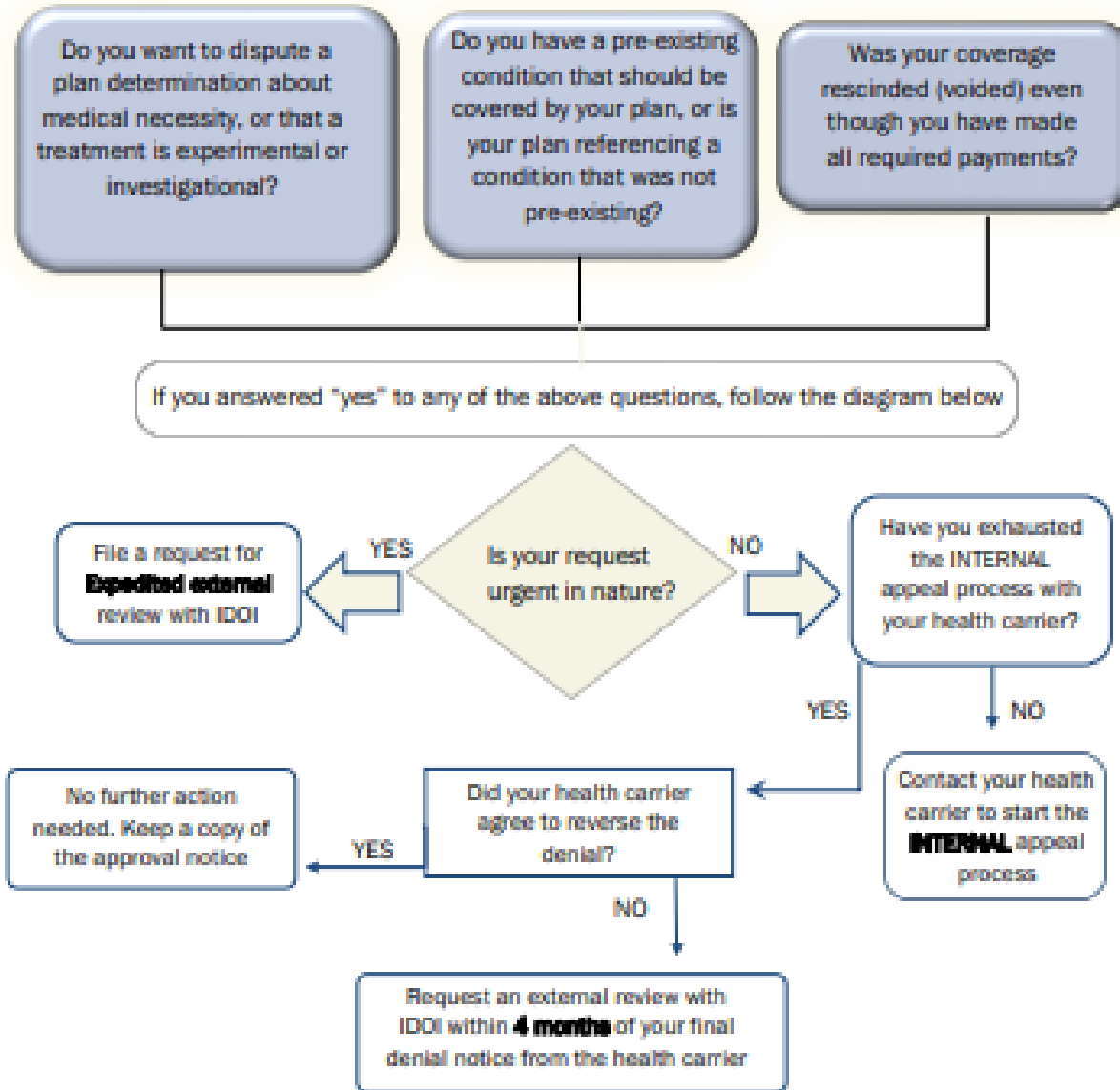
Fax at (217) 558-8495

Mail to 320 W. Washington Street, Springfield IL 62767

Forms are available on our website at [insurance.illinois.gov](https://insurance.illinois.gov) or contact external review staff at 877-850-4740 if you need assistance.

- Request for external review - **REQUIRED**
- Physician Certification - Expedited | Experimental/Investigational (if applicable)
- Appointment of Authorized Representative – (if applicable)

**Follow the diagram to help decide whether you should file for an external review.**



For more about external review, visit our website [insurance.illinois.gov](http://insurance.illinois.gov) or contact external review staff at (877) 850-4740



# Illinois Department of Insurance

## Request for External Review

320 West Washington Street  
Springfield, IL 62767-0001  
Toll-free 877-850-4740  
TDD: 866-323-5321  
Fax: 217-557-8495

[DOL.externalreview@illinois.gov](mailto:DOL.externalreview@illinois.gov)

Revised 3/2020

Is this request **URGENT**? Does the patient have a medical condition where the timeframe for completion of an expedited internal appeal (48 hours), a final adverse determination (15-30 days), or a standard external review (21-45 days) would seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function?

NO  YES - (If yes, the Physicians Certification Expedited Review form is **REQUIRED**)

**NOTE:** By requesting an expedited external review, you are waiving any available appeal steps and will not have an opportunity to submit additional information after this request.

PATIENT INFORMATION			
Last		First	
MI			
Address		City	State
		Zip	
Phone Number	Email		

INSURANCE INFORMATION			
Insurance Company Name		Policy ID	
Policy Holder Name		Employer/Sponsor Name	
Plan Type	Individual Plan <input type="checkbox"/>	Group Plan - Employer <input type="checkbox"/>	Group Plan - Sponsor <input type="checkbox"/>

HEALTH CARE PROVIDER INFORMATION			
Organization/Doctor's Name		Phone Number	
Address		City	State
		Zip	
Fax Number	Email		
Contact Person	Contact Preference	Mail <input type="checkbox"/>	Email <input type="checkbox"/>
		Fax <input type="checkbox"/>	

REASON FOR EXTERNAL REVIEW			
If the denial reason is <b>NOT</b> listed, please call 877-850-4740 prior to filing			
Medical Necessity <input type="checkbox"/>	Pre-existing Condition <input type="checkbox"/>	Rescission of Coverage <input type="checkbox"/>	Experimental/Investigational <input type="checkbox"/>
Date(s) of Service (REQUIRED)		Date of Denial (attach letter if possible)	

### **HEALTH CARE DECISION IN DISPUTE**

**Include any information you have about the healthcare services, supplies or medications being denied.**

### **REQUEST FOR EXTERNAL REVIEW CHECKLIST**

**Include the Following Items:**

**Proof of Legal Representation** – **REQUIRED IF** the applicant is not the patient or parent of the minor child.

**Physician Certification Experimental/Investigational Form** – **REQUIRED IF** the health care service or course of treatment has been denied on the basis that the drug, procedure, therapy or services has been determined to be experimental or investigational. Must be completed by the treating provider.

**Physician Certification Request for Expedited Form** – **REQUIRED IF** the covered person has a medical condition where the timeframe for completion of an expedited internal appeal (48 hours), a final adverse determination (15-30 days), or a standard external review (21-45 days) would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. **By requesting an expedited external review, you are waiving appeal steps and you will not have an opportunity to submit additional information after this request.**

**Final Denial Letter** – copy of the final denial letter from the Health Carrier, denying your request at the final level of their internal appeals process. For an expedited External Review, attach the last denial letter received.

**ID Card** – A copy of the patient's insurance identification card.

**Related Medical Records and Supporting Documentation** – Include any documentation that supports your assertion that this medical treatment should be covered, such as available pertinent medical records, any information you received from your health carrier concerning the denial, any pertinent peer literature or clinical studies, and any additional information from the physician/health care provider that you want the independent review organization to consider.

**IMPORTANT INFORMATION**

**Filing Deadline** – You have **4 months** to file your external review after receipt of the final denial letter indicating that the internal appeals have been exhausted.

**Expedited External Review for Urgent Care or Life Threatening Situations** – Expedited external review requests should be filed immediately following receipt of any adverse determination. Please provide all additional information with this form; you will not be given another opportunity to provide this information.

**New Medical Information** – Be sure to submit any new medical information that you wish to have considered. All previously submitted medical information will automatically be forwarded to the independent review organization by the health plan for consideration in this external review.

**PATIENT CONSENT FOR EXTERNAL REVIEW AND RELEASE OF MEDICAL RECORDS**

**Patient, Parent of a Minor Child, or Legal Representative**

(Legal Representative - guardian, power of attorney, executor or administrator - **MUST** attach official documentation).

By signing below, I hereby authorize the release of medical records necessary for this external review. I understand that these records may be obtained from the insurance carrier, the utilization review company, and/or any relevant medical provider(s) and will be utilized solely for the purpose of conducting this external review and may be viewed by an auditor of the Department of Insurance for quality review and examination of record purposes.

**I understand that information relating ONLY to this review will be shared with the authorized individual**

Patient, Parent or Legal Representative  
Signature ONLY \_\_\_\_\_ Date \_\_\_\_\_

**IF YOU ARE NOT THE PATIENT, PARENT OR LEGAL REPRESENTATIVE**  
Please complete the "Appointment of Authorized Representative" Form and submit with this request.

**Send completed form and any supporting documents to:**

Illinois Department of Insurance  
Office of Consumer Health Insurance  
320 West Washington Street  
Springfield, IL 62767

FAX 217- 557-8495  
EMAIL [DOI.complaints@illinois.gov](mailto:DOI.complaints@illinois.gov)  
File electronically at <http://insurance.illinois.gov>  
Toll-free Consumer Hotline: 877-850-4740  
TDD: 866-323-5321

Submit Form





# Illinois Department of Insurance

## Physician Certification Expedited Review

320 West Washington Street  
Springfield, IL 62767  
877-850-4740 Toll-free  
TDD: 866-323-5321  
Fax: 217-557-8495

[DOI.externalreview@illinois.gov](mailto:DOI.externalreview@illinois.gov)

**This review is NOT if available if services have already been provided**

Revised 3/2020

This form is to be completed by the treating physician when the patient has a medical condition where the timeframe for completion of an expedited internal appeal (48 hours), a final adverse determination (15-30 days), or a standard external review (21-45 days) would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function.

**NOTE:** By requesting an expedited external review, you are waiving any available appeal steps and will not have an opportunity to submit additional information after this request.

PATIENT INFORMATION			
Last	First	MI	
Address	City	State	Zip
HEALTH CARE PROVIDER INFORMATION			
Treating Health Care Provider Name		Area of Clinical Specialty	
Address	City	State	Zip
Contact Person		Phone	
Email		Fax	

I hereby certify that in my opinion, the above named patient who has received an adverse determination for the medical services that I have recommended as medically necessary requires such review to be provided on an expedited basis because a delay would seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function or in the case of an experimental/investigational adverse determination, that the recommended health care service or treatment would be significantly less effective if not promptly initiated.

Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

Send completed form and any supporting documents to:

Illinois Department of Insurance  
Office of Consumer Health Insurance  
320 West Washington Street  
Springfield, IL 62767

FAX (217) 557-8495  
Email [DOI.externalreview@illinois.gov](mailto:DOI.externalreview@illinois.gov)  
Submit on-line at <http://insurance.illinois.gov>  
Toll-free Consumer Hotline: 877-850-4740  
TDD - 866-323-5321

Submit Form





# Illinois Department of Insurance

## Appointment of Authorized Representative Form

320 West Washington Street  
 Springfield, IL 62767  
 Toll-free 877-850-4740  
 TDD: 866- 323-5321  
 FAX: 217-557-8495

[DOI.externalreview@illinois.gov](mailto:DOI.externalreview@illinois.gov)

Revised 3/2020

This form is to be completed when someone other than the patient, parent, or guardian is representing the patient in this appeal. Health Care Providers must have this form completed in order to act as an Authorized Representative. This authorization may be revoked at any time with written notification to the Department of Insurance.

<b><u>PATIENT INFORMATION</u></b>				
Last		First		MI
Address		City	State	Zip
Date of Birth	Phone Number	Email		
<b><u>PERSON I AUTHORIZE TO PURSUE MY APPEAL (AUTHORIZED REPRESENTATIVE)</u></b>				
Relationship to Patient				
Last		First		MI
Address		City	State	Zip
Phone Number		Email		
Organization Name (if applicable)		Complaint Number (if applicable)		
<b><u>SIGNATURE FOR AUTHORIZATION</u></b>				
I authorize the above identified person to pursue this review on my behalf and to have access to my personal health information and financial information. I understand that my approval of this authorization is voluntary and that I may end my approval of this authorization, in writing, at any time.				
By signing below I hereby authorize the release of medical records necessary for this review. I understand that these records may be obtained from the insurance carrier, the utilization review company, and/or any relevant medical provider(s) and will be utilized solely for the purpose of conducting this review and may be viewed by an auditor of the Department of Insurance for quality review and examination of record purposes.				
I understand that information related ONLY to this review will be shared with the authorized individual.				
Signature of Patient (if under 18, signature of parent or guardian)		Date		

Submit Form

**Attachment D: Appeal Decision Reversal**

Date

SENT VIA CERTIFIED MAIL

Name of Subscriber/Authorized Representative  
Address  
City/State/Zip

Member Name:	Claim Number(s):
Member Number:	Claim Amount:
Date of Service:	Provider Name:
Date of Receipt of Appeal:	

Dear Ms./Mr. \_\_\_\_\_:

This letter is in response to your appeal of an adverse benefit determination for the above-referenced claim. Medical Associates Health Plans (MAHP) takes all appeals seriously and is committed to a thorough review and timely response. As a Member entitled to benefits under the **[Group Name]** Subscriber Agreement, your appeal is important, and I have conducted an investigation into this claim.

Our records indicate that this claim original denied as **[INSERT]**. After reviewing the facts of this case, the original decision to deny **<coverage and/or payment>** has been reversed. Coverage for **<service>** will be processed and paid according to the benefits and limitations of your Subscriber Agreement and subject to any applicable copayments or cost sharing.

If we may answer any questions or be of any further assistance, please contact the MAHP Member Services Department by phone at 563-584-4885 or 1-866-821-1365 (toll free), or by email at [memberservices@mahealthcare.com](mailto:memberservices@mahealthcare.com).

Sincerely,

(HCS Staff name and title)  
Medical Associates Health Plan, Inc.

cc: Member *(include only if letter sent to Authorized Representative)*

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-821-1365 (TTY: 1-800-735-2942).

**Attachment E: Request for Additional Information**

Date

SENT VIA CERTIFIED MAIL

Name of Subscriber/Authorized Representative  
Address  
City/State/Zip

Member Name:	Claim Number(s):
Member Number:	Claim Amount:
Date of Service:	Provider Name:
Date of Receipt of Appeal:	

Dear Mr./Ms. \_\_\_\_\_:

Medical Associates Health Plans (MAHP) recently received your appeal with respect to the above-referenced claim. The purpose of this letter is to notify you that additional information is required to evaluate your appeal.

We have requested additional information from (provider/facility) on (date). You may want to contact (provider/facility) on the status of this request. Or Please provide the following information at your earliest convenience: [INSERT]

Once all the information is received, MAHP will make a decision on your appeal in accordance with applicable law. If you have any questions on pre-service claims, please call Health Care Services at (563) 584-3275 or 1-800-325-7442 or Member Services at (563) 584-4885 or 1-866-821-1365.

Sincerely,

[Member Services Staff name and title]

or

[Health Care Services Staff name and title]

Medical Associates Health Plan, Inc.

cc: Member *(include only if letter sent to Authorized Representative)*

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-821-1365 (TTY: 1-800-735-2942).

# Appointment of Authorized Personal Representative and Authorization to Release Protected Health Information

**Attachment F**

<b>Member Information</b>	
Member Name	Member ID#
Mailing Address	
E-Mail Address	Phone Number

<b>Appointment of Authorized Personal Representative</b>
<p>I appoint the individual named below to act on my behalf as my Authorized Personal Representative with Medical Associates Health Plans in connection with:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> All my claims for health care benefits on and after the effective date of this appointment.</li> <li><input type="checkbox"/> My inquiries and claims for health care benefits with respect to the following dates of service only: _____ _____</li> <li><input type="checkbox"/> My appeal of a pre-service or post-service claim for benefits that was denied (an adverse benefit determination). <i>Specify date of denial letter, date of service or claim number: _____</i> <i>For a denial of benefits related to a claim for a service you already have received, this information may be found on your Explanation of Benefits.</i> <i>Specify name of provider: _____</i></li> </ul>

<b>Identification of Member's Authorized Personal Representative</b>	
Personal Representative Name	Relationship to Member
Mailing Address	
E-Mail Address	Phone Number

<b>Expiration of Appointment of Authorized Personal Representative</b>
<p>This appointment of personal representative and authorization to release protected health information will expire 30 days after termination of my health plan coverage, or upon settlement of claims incurred while covered, unless revoked or an earlier date or event is entered below.</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> On ____/____/____</li> <li><input type="checkbox"/> At the conclusion of all proceedings relating to my appeal of a pre-service or post service claim for benefits that was denied (adverse benefit determination), or one year, whichever is later.</li> <li><input type="checkbox"/> On occurrence of the following event*: _____</li> </ul> <p style="text-align: center; margin-top: 10px;">* Event must relate to the individual or the purpose of the use or disclosure of protected health information.</p>

## Authorization to Disclose or Release Protected Health Information

- I authorize and consent to the release and disclosure of my protected health information (PHI) to the individual named as my Authorized Personal Representative for the claim(s) for benefits set forth above. I authorize and consent to the release and disclosure of my PHI for as long as this Appointment of Authorized Personal Representative is in effect.
- I authorize Medical Associates Health Plans to directly communicate with the individual named in this appointment form with respect to all matters relating to the claim(s) for benefits set forth above.
- I understand that my Authorized Personal Representative will receive (on my behalf) notifications that I am otherwise entitled to receive under federal and/or state laws pursuant to my claim for benefits.
- I understand that once PHI is disclosed, Medical Associates Health Plans cannot guarantee that the Authorized Personal Representative will not re-disclose the information to a third party.
- I understand that I may inspect the mental health information disclosed (if any).
- I understand that this authorization is voluntary and I may revoke it at any time by giving written notice of my revocation to Medical Associates Health Plans at the address stated below. I understand that revocation of this appointment and authorization will not affect any action taken by Medical Associates Health Plans in reliance on this appointment and authorization before the written notice of revocation was received.
- I understand that this authorization is effective immediately upon signature and will remain in effect until a written notice of revocation is provided to Medical Associates Health Plans or through the end of enrollment with Medical Associates Health Plans.

In accordance with federal and/or state laws, special permission is required for disclosure if information pertains to any of the categories listed below. Identify and authorize the release of this information by selecting the boxes that apply.

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Developmental Disabilities  | <input type="checkbox"/> HIV-Related Information (AIDS) | <input type="checkbox"/> Sexually Transmitted Diseases                       |
| <input type="checkbox"/> Genetic Testing Information | <input type="checkbox"/> Mental Health Information      | <input type="checkbox"/> Substance Use Disorders (alcohol and/or drug abuse) |

## Required Signatures

Member / Legal Guardian\* Signature \_\_\_\_\_ Date \_\_\_\_\_

- \* *Member must be at least 18 years of age or otherwise legally competent to make such authorization. If you are a Legal Guardian (other than a parent), a copy of valid guardianship documentation must be submitted with this form.*

Print Name of Legal Guardian \_\_\_\_\_

### Return completed form to:

Medical Associates Health Plan, Inc.  
1605 Associates Drive, Suite 101  
Dubuque, IA 52002

Fax: (563) 584-4760  
E-mail: [MemberServices@mahealthcare.com](mailto:MemberServices@mahealthcare.com)

**RETAIN A COPY FOR YOUR RECORDS**

## Appeal Form

This form is to be completed by you, as a covered Member, or your Authorized Representative (if you have designated one), if you disagree with a benefit determination and request a review of a claim for benefits that has been denied.

Member Information		
Member Name	Member ID	Date of Birth
Mailing Address		
Phone Number	E-mail Address	Subscriber Name <i>(if different from member)</i>

Legal Guardian / Legal Representative / Authorized Personal Representative	
<i>* If you are requesting an appeal on behalf of a Member, you must be the Member's legal guardian or legal representative, or an Appointment of Authorized Personal Representative Form must be submitted with this form or already on file with Medical Associates Health Plans. A Member may appoint only one Authorized Personal Representative at a time.</i>	
This appeal is being requested by <i>(Insert Full Name)</i>	Relationship to Member
Mailing Address	Phone Number

Claim Information <i>(This information may be found on the front of your Explanation of Benefits or letter of denial.)</i>	
Has the service in question already been provided?	
<input type="checkbox"/> Yes Date of Service(s): Provider Name: Claim Number(s):	<input type="checkbox"/> No Date of Denial: Provider Name:

Please include an explanation of your appeal and a statement of the action you would like taken in response to your appeal. Attach any and all documentation (written comments, records, or other documents) that may support your appeal. **This appeal must be filed within 180 days of the date on the Explanation of Benefits or letter of denial of coverage.** You will receive a written response within the time required by law. For more information, consult your Subscriber Agreement, or contact Member Services at (563) 584-4885, or toll free at 1-866-821-1365, or by email to [MemberServices@mahealthcare.com](mailto:MemberServices@mahealthcare.com).

Are there documents attached?    Yes    No

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Return completed form to:**  
 Medical Associates Health Plan, Inc.  
 1605 Associates Drive, Suite 101  
 Dubuque, IA 52002

Fax: (563) 584-4760  
 E-mail: [MemberServices@mahealthcare.com](mailto:MemberServices@mahealthcare.com)

Retain for your records a copy of this form and any additional documentation submitted in support of your appeal.