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AGENDA ITEM

☐ Action Item

☒ Information Only

Date: March 28, 2024

Item Number: 9

Title: Claims Appeal Process Report

SUMMARY

This report provides the PEBP Board and members of the public with information regarding the process a member may pursue to appeal an adverse medical claim determination. The same process largely applies to adverse dental, utilization management, recission of coverage, and Health Reimbursement Arrangement (HRA) claim determinations.

REPORT

CLAIMS PROCESS

When a member receives health care services, the provider typically submits a claim to UMR for processing. Claims include information necessary to process the claim, such as identification information, dates of service, service codes (also known as CPT, CDT, HCPCS, etc.), and diagnosis codes.

UMR notifies the member in writing of how the claim is processed, including the reason for any adverse determination and the plan provision on which such adverse determination is based. If the adverse determination is based on a lack of information, UMR requests additional information that may support reversal of the adverse determination. UMR's explanation also explains the process for initiating a formal appeal of the decision.

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If a member believes a claim has been processed incorrectly, the member will often call UMR, and UMR may reprocess the claim. Such reprocessing is not part of the formal appeal process, and often resolves the member's concerns.

If a member is dissatisfied with reprocessing or chooses not to seek it in the first instance, the member may proceed directly to the formal appeal process, the details of which are set forth in Chapter 287 of the Nevada Administrative Code (NAC), *see* NAC 287.600-.695, and are discussed below.

APPEALS

There are three levels of claim appeals, which PEBP refers to as Level 1 Claim Appeals, Level 2 Claim Appeals, and Requests for External Review.

Level 1 Claim Appeal - UMR

Level 1 Claim Appeals are handled in compliance with NAC 287.670. To initiate a formal appeal of an adverse determination, a member must submit a written request to UMR within 180 days of receiving notice of the determination. Members may submit such appeals online through UMR's portal.

Within 20 days of receiving the appeal, a UMR appeals manager reviews it and determines if the claim was resolved consistent with the terms and conditions of the applicable governing documents and informs the member in writing of the decision. The decision must include the reasons for the decision, the provision of the plan on which the decision is based, and how the member may appeal the decision to PEBP.

UMR sends PEBP a monthly report of Level 1 Claim Appeals, which Quality Control staff reviews and discusses with UMR, including how the process may be improved.

In 2023, members filed 163 Level 1 Claim Appeals with UMR; the initial adverse determination was overturned in 47 of those appeals.

Level 2 Claim Appeal - PEBP

Level 2 Claim Appeals are resolved pursuant to the procedure set forth in NAC 287.680. If a member is dissatisfied with the decision of the UMR appeals manager at the Level 1 Claim Appeal level, the member may, within 35 days of receiving that decision, file a written appeal with PEBP, which may be completed via PEBP's website.

Within 30 days of receiving a Level 2 appeal, PEBP's Quality Control staff reviews the appeal to determine if the claim was resolved consistent with the terms and conditions of the applicable governing documents and informs the member in writing of the decision. The decision must include the reasons for the decision, the provision of the plan on which the decision is based, and how the member may seek external review of PEBP's decision.

While Quality Control staff always provides a written decision on a Level 2 appeal, they will also often call a member to discuss the forthcoming written decision, especially if the matter is

especially complex or sensitive. Quality Control staff is currently focusing on revisiting its procedures to ensure that the written decisions for Level 2 Claim Appeals are thoroughly explanatory, professional, and concise, and is working closely with the Executive Officer to improve the member experience of the process as much as possible.

In 2023, members filed 36 Level 2 Claim Appeals, of which 7 were overturned. PEBP shares with UMR the outcomes of these appeals and works with UMR to improve application of the plan rules going forward.

Requests for External Review

If a member is not satisfied with PEBP's decision on a Level 2 Claim Appeal, and PEBP's decision "involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service of treatment" the member requested, the member may request an external review conducted by an independent review organization pursuant to NRS 695G.241-.310.

When claims go to external review, PEBP works with the Nevada Office for Consumer Health Assistance (OCHA) and its vendors to submit relevant records to the OCHA-assigned external review organization.

In 2023, members filed 13 Requests for External Review, of which 4 were overturned.

EXCEPTIONS TO PLAN RULES

In addition to the appeals process, members may request an exception to plan rules. As set forth in the plan documents, PEBP has discretionary authority to interpret and make determinations regarding benefits in accordance with the terms of the plan.

One of the primary requests for exception addresses gaps in coverage. For example, the Exclusive Provider Organization plan is regionally restricted with no out-of-network benefits. When there are no local providers for a specific service, the plan allows the Utilization Management company to give prior authorization for a "gap exception," which allows members to visit out-of-network providers near their homes.

Members also request other exceptions to the application of plan rules. When a member requests an exception to allow coverage for a medical procedure, Quality Control staff reviews the request and supporting information, as well as publicly available industry standards, such as clinical policy from Medicare, Medicaid, or commercial health insurance providers. Another category of exception requests involve eligibility, for example, to add a dependent. After their review, Quality Control staff will share findings and make a recommendation to the Executive Officer, who has the sole authority to make such exceptions.