



**COMMONWEALTH OF VIRGINIA
DEPARTMENT OF HUMAN RESOURCE MANAGEMENT**

Group Administrator Memo #00-02

To: Group Benefits Administrators
From: Charles S. Reed, Associate Director
State and Local Health Benefits Programs
Date: November 1, 2000
Re: --External Review Introduced for Regional Plans
--Brief Notes on Health Benefits, Newborns and Dependents

External Review for Regional Plans

The State Corporation Commission's Bureau of Insurance now has a procedure for external review of appeals accepted from employees enrolled in the Commonwealth's regional health plans. Here's how the process works:

- Once internal health plan appeals are exhausted, members may file for an external review of coverage denied as not being medically necessary or as experimental/investigative. All appeals must be filed within 30 days of the final plan decision to deny coverage, and the claim must exceed \$300 to be eligible for appeal.
- If the appeal is accepted, an independent health care review organization, not affiliated with the member's health plan, will be asked to conduct a review of the appeal.
- A written recommendation will be made to the Commissioner of Insurance, who will issue a written ruling. The ruling is binding, with no opportunity for appeal.
- Additional information: (804) 371-9032 in Richmond or toll-free at (877) 310-6560, also www.state.va.us/scc.

Health Benefits Briefs

- For the Key Advantage and Cost Alliance plans, pre-authorization is no longer required for a colonoscopy as of July 1. This is the result of legislative changes and a subsequent change in Trigon corporate policy.
- Limited retroactivity is provided to protect an employee in the event of an error in the administration of the employee's health benefits. Beginning with the July 1, 2000 contracts, HMOs limit retroactive changes to a period of 60 days. The previous limit was 90 days. There is no change in the contractual limitation for the Key Advantage and Cost Alliance plans.

Coverage for Newborns

Employees expecting a baby must add their newborn as a dependent on their health plan so the baby will have health coverage, and select a primary care physician (PCP) for the infant. Within 31 days of the child's birth, employees should submit a completed Enrollment/Waiver form to their benefits administrator and a PCP selection form to their health plan.

Dependents Having a 23rd Birthday

Remember to remind employees to drop a son or daughter who turns 23 in 2000 as a dependent on their health plan at the end of the year. Any child turning 23 can no longer be carried as a dependent on an employee's health plan at the end of the calendar year in which the birthday occurs, or the end of the month in which he or she becomes self-supporting, whichever is first. When a dependent marries, he or she becomes ineligible for an employee's plan.

Dependent children with a disability, regardless of their age, may continue to be covered if they cannot be self-supporting because of a severe mental or physical disability diagnosed while enrolled in the employee's health plan. However, remember that to continue coverage an employee must submit a request and supporting medical documentation to the plan prior to the time the disabled child becomes ineligible for coverage due to age.