



COMMONWEALTH OF VIRGINIA
DEPARTMENT OF HUMAN RESOURCE MANAGEMENT
THE LOCAL CHOICE

The Local Choice Health Benefits Program Appeals Process

The Local Choice (TLC) Health Benefits Program (Program) has a specific appeals procedure for employees in the self-funded plans. These plans are **Key Advantage With Expanded Benefits, Key Advantage 250, Key Advantage 500, Key Advantage 1000, TLC High Deductible Health Plan [HDHP]**. When a member of the TLC health plan receives a final, adverse decision from their health plan administrator, they may appeal the denial to the plan administrator (internal appeal process). If the plan administrator issues an unfavorable final decision, then the member may appeal to the Director of the Department of Human Resource Management (DHRM) (external appeal process). Appeals regarding denied claims are reviewed by an independent review organization.

For appeals relating to the TLC Regional Plan, please refer to “**For Non-Self Funded TLC Health Plans**” found later in this document.

The Program also provides an appeal process for issues related to the eligibility of members for the health benefits plans and includes denials of enrollment requests and election changes. The member may appeal directly to the Director of DHRM for these issues. The Program will not accept eligibility appeals for matters in which the sole issue is a disagreement with policies, rules, regulations, contract or law.

If you are unsure whether a determination can be appealed, you can contact the Office of Health Benefit Programs at (804) 225-3642 or (888) 642-4414.

What Is The Process For Filing an Appeal?

Self-funded TLC Health Plans:

Before filing a health care appeal to the Director of DHRM, you must exhaust all health care appeals through your plan administrator. You must submit your appeal request in writing within four (4) months of the final, adverse decision by your plan administrator. Note that you may only appeal adverse benefit determinations by the plan administrator that are based on your Health Plan’s requirements for medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, or the failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational.

In some circumstances, you have the right to an expedited appeal. An expedited appeal means the independent review organization will render a decision in a shorter timeframe. However, in order to request an expedited appeal you must meet the criteria listed in the Key Advantage Member Handbook, as follows:

Expedited external appeals may be submitted to DHRM by telephone, facsimile or email at the time that you receive:

- An adverse decision from your Plan Administrator, if the adverse decision involves a medical condition for which the time frame for completing an expedited internal appeal (see Expedited Internal Appeals above) would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, and you or your authorized representative has requested an expedited internal appeal from the Plan Administrator;
- A final adverse decision of an internal appeal from the Plan Administrator, if the adverse decision involves a medical condition for which the time frame for completing a standard external appeal (see Standard External Appeals above) would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final adverse decision concerns an admission, availability of care, continued stay, or health care service for which you received Emergency services, but have not been discharged from a Facility; or
- A final adverse decision of an internal appeal from the Plan Administrator, if the adverse decision involves prescriptions to alleviate cancer pain.

When a health care claim appeal is submitted to the Director of DHRM, the denial of coverage will be reviewed by an independent review organization. If the appeal is not expedited, you will receive an “Appeal Notice” informing you to submit additional supporting documentation to the independent review organization within five (5) days of receiving the notice. It is the responsibility of the independent review organization to confidentially examine the final denial of claims to determine whether the decision of the plan is objective, clinically valid and compatible with established principles of health care.

Once the independent review organization has made a decision, it must provide written notification to you, DHRM, and the plan administrator. The outcome of the independent review may be either to overturn or uphold the denial. If the independent review organization upheld or partially upheld the plan administrator’s denial, the member will be notified that, if desired, he or she may exercise the appeals process under the Administrative Process Act (APA).

For Eligibility Appeals :

If your appeal is regarding eligibility, the Director of DHRM will offer an informal fact-finding consultation. A decision will be rendered. If the claim remains denied, specific written reasons will be given, including specific references to law, regulation, contract provisions or relevant policies which formed the basis for the denial. Also, at this level, the employee will be notified that, if desired, he or she may exercise the appeals process under the Administrative Process Act (APA).

For Non-Self Funded TLC Health Plans:

If you are enrolled in the Kaiser Permanente regional plan, you may appeal claims decisions to the State Corporation Commission (SCC) after you have exhausted internal appeals with the health plan. For more information, you may call (804) 371-9032 in Richmond or toll-free at (877) 310-6560, or access the SCC website at www.state.va.us/scc. Only appeals involving eligibility or policy may be sent to the Director of DHRM for non-self funded TLC Health Plans.

What Are The Steps In the DHRM Appeals Process?

- Be sure that you have exhausted all internal appeals under your health plan.
- If you are enrolled in a self-funded TLC plan (Key Advantage With Expanded Benefits, Key Advantage 250, Key Advantage 500, Key Advantage 1000, TLC HDHP), file an appeal in writing with the Director of DHRM within four (4) months of the final adverse decision by your health plan.
- File appeals regarding eligibility with DHRM within four (4) months of an adverse decision.
- Submit the following:
 - Your full name
 - Your identification number
 - Your address
 - Your telephone number
 - The date(s) of the medical service
 - Your specific medical condition(s) or symptom(s)
 - Your provider's name
 - The service or supply for which approval of benefits is being sought, and
 - Any reasons why the appeal should be processed on an expedited basis.
- You may download an external appeals form at <http://www.thelocalchoice.virginia.gov/forms.html> or obtain a copy from your Group Benefits Administrator at your place of employment.
- You are responsible for providing DHRM with all information necessary to review the denial of your claim.
- If the final health plan decision concerns a health care claim, the claim will be reviewed by an independent clinical review organization.
- For eligibility appeals, the Director of DHRM will offer an informal, fact-finding consultation as part of the appeals process. The Director will render a decision pertaining to the eligibility denial.

In accordance with HIPAA Privacy, for medical and mental health and substance abuse claims, you must submit a HIPAA Authorization Form to DHRM before your appeal can be processed. The form is available on the TLC website at <http://www.thelocalchoice.virginia.gov/forms/appealform.pdf> or may be requested from your Group Benefits Administrator.