

**ARIZONA APPEALS INFORMATION PACKET  
GRANDFATHERED PLANS  
GOLDEN RULE INSURANCE COMPANY**

*Please read this notice carefully. It contains important information regarding how to appeal decisions made by us and our review agent. These procedures only apply to covered persons while they reside in Arizona.*

**Getting Information About the Health Care Appeals Process  
Help in Filing an Appeal: Standardized Forms and Consumer Assistance From  
the Department of Insurance and Financial Institutions**

We must send you a copy of this information packet when you first receive your plan and provide access to a copy of the information packet on our website. We have also included with your policy/certificate an Arizona Appeals Information Packet provision in the Arizona Endorsement to remind you that you can request another copy of this packet. We will also send a copy of this packet to you or your treating provider at any time upon request. Just call our Client Services Department at (800) 657-8205 to ask.

Enclosed with this packet, you will find forms you can use for your appeal. The Arizona Department of Insurance and Financial Institutions (“the Department”) developed these forms to help people who want to file a health care appeal. You are not required to use them. We cannot reject your appeal if you do not use them. If you need help in filing an appeal, or you have questions about the appeals process, you may call the Department’s Consumer Services Section at (602) 364-2499 or (800) 325-2548 (outside Phoenix), or call us at the number listed above.

**How to Know When You Can Appeal**

When we or our review agent do not recommend a service or pay a claim, we must notify you of your right to appeal that decision. Your notice may come directly from us or through your treating provider.

**Decisions You Can Appeal**

You can appeal the following decisions:

- A. We or our review agent do not recommend a service that you or your treating provider has requested.
- B. We do not pay for a service that you have already received.
- C. We or our review agent do not recommend a service or pay a claim because we say that it is not “medically necessary”.
- D. We or our review agent do not recommend a service or pay a claim because we or our review agent say that it is not covered under your insurance policy, and you believe it is covered.
- E. We or our review agent do not notify you, within ten (10) business days of receiving your request, whether or not we or our review agent will recommend a requested service.
- F. We do not authorize a referral to a specialist.

**Decisions You Cannot Appeal**

You cannot appeal the following decisions:

- A. You disagree with our decision as to the amount of “reasonable and customary” charges.
- B. You disagree with how we are coordinating benefits when you have health insurance with more than one insurer.
- C. You disagree with how we have applied your claims or services to your plan deductible.
- D. You disagree with the amount of coinsurance or copayment that you are required to pay under your policy/certificate of coverage.
- E. You disagree with our decision to issue or not issue coverage to you.
- F. You are dissatisfied with any rate increases you may receive under your insurance plan.

G. You believe we have violated any other parts of the Arizona Insurance Code.

If you disagree with a decision that is not appealable according to this list, you may still file a complaint with the Arizona Department of Insurance and Financial Institutions, Consumer Services Section, 100 N. 15<sup>th</sup> Avenue, Suite 261, Phoenix, AZ 85007. You can also file a complaint via our website: [www.difi.az.gov](http://www.difi.az.gov).

### **Who Can File An Appeal?**

Either you or your treating provider can file an appeal on your behalf. Enclosed with this packet is a form that you may use for filing your appeal. You are not required to use this form, and you may send us a letter with the same information. If you decide to appeal our decision to deny a recommendation for a service, you should tell your treating provider so the provider can help you with the information you need to present your case.

### **Description of the Appeals Process**

There are two types of appeals: an expedited appeal for urgent matters and a standard appeal. Each type of appeal has three (3) levels. The appeals operate in a similar fashion, except that expedited appeals are processed much faster because of the patient's condition.

	<b>Expedited Appeals</b> <u>(for urgently needed services you have not yet received)</u>	<b>Standard Appeals</b> <u>(for non-urgent services or denied claims)</u>
Level 1 –	Expedited Medical Review	Informal Reconsideration
Level 2 –	Expedited Appeal	Formal Appeal
Level 3 –	Expedited External Independent Medical Review	External Independent Medical Review

We or our review agent make the decisions at Level 1 and Level 2. An outside reviewer, who is completely independent from us or our review agent, makes Level 3 decisions. You are not responsible to pay the costs of the external review if you choose to appeal to Level 3.

### **EXPEDITED APPEAL PROCESS FOR URGENTLY NEEDED SERVICES NOT YET PROVIDED**

#### **Level 1 – Expedited Medical Review**

**Your request:** You may obtain Expedited Medical Review of your denied recommendation for a service that has not already been provided if:

- A. You have coverage with us;
- B. We or our review agent have not recommended your request for a covered service; and
- C. Your treating provider certifies in writing and provides supporting documentation that the time required to process your request through the Informal Reconsideration and Formal Appeal process (about 60 days) is likely to cause a significant negative change in your medical condition. (Enclosed with this packet is a form that your provider may use for this purpose. Your provider could also send a letter or make up a form with similar information.) Your treating provider must send the certification and documentation to:

Grievance Administrator  
3100 AMS Boulevard  
Green Bay, WI 54313  
Phone: (800) 657-8205  
Fax: (866) 654-6323

**Our decision:** We have one (1) business day after we or our review agent receives the information from the treating provider to decide whether we should change our decision. Within that same business day, we must call and tell you and your treating provider and mail you our decision in writing. The written decision must explain the reasons for our decision and tell you the documents on which we based our decision.

<b>If we deny your request:</b>	You may immediately appeal to Level 2.
<b>If we grant your request:</b>	We or our review agent will recommend the service and the appeal is over.
<b>If we refer your case to Level 3:</b>	We or our review agent may decide to skip Level 1 and Level 2 and send your case straight to an independent reviewer at Level 3.

**Level 2 – Expedited Appeal**

**Your request:** If we or our review agent deny your request at Level 1, you may request an Expedited Appeal. After you receive our Level 1 denial, your treating provider **must immediately** send us or our review agent a written request (to the same person and address listed under Level 1) to tell us you are appealing to Level 2. To help your appeal, your provider should also send us or our review agent any more information (that the provider has not already sent us) to show why you need the requested service.

**Our decision:** We or our review agent have three (3) business days after we or our review agent receive the request to make our decision.

<b>If we deny your request:</b>	You may immediately appeal to Level 3.
<b>If we grant your request:</b>	We recommend the service and the appeal is over.
<b>If we refer your case to Level 3:</b>	We or our review agent may decide to skip Level 2 and send your case straight to an independent reviewer at Level 3.

**Level 3 – Expedited External, Independent Review**

**Your request:** You may appeal to Level 3 only after you have appealed through Levels 1 and 2. You have only five (5) business days after you receive our or our review agent’s Level 2 decision to send us your written request for Expedited External Independent Review. Send your request and any more supporting information to:

Grievance Administrator  
 3100 AMS Boulevard  
 Green Bay, WI 54313  
 Phone: (800) 657-8205  
 Fax: (866) 654-6323

Neither you nor your treating provider is responsible for the cost of any external independent review.

**The process:** There are two types of Level 3 appeals, depending on the issues in your case:

A. **Medical Necessity**

These are cases where we have decided not to recommend a service because we think the services you (or your treating provider) are asking for are not medically necessary to treat your problem. For medical necessity cases, the independent reviewer is a provider retained by an outside independent review organization (“IRO”) that is procured by the Arizona Department of Insurance and Financial Institutions and not connected with our company. The IRO reviewer must be a provider who typically manages the condition under review.

B. **Contract Coverage**

These are cases where we have denied coverage because we believe the requested service is not covered under your insurance plan. For contract coverage cases, the Arizona Department of Insurance and Financial Institutions is the independent reviewer.

**Medical Necessity Cases**

Within one (1) business day of receiving your request, we or our review agent must:

- A. Send a written acknowledgment of the request to the Director of the Department of Insurance and Financial Institutions (“Director”), you, and your treating provider.

- B. Send the Director: the request for review; a copy of your insurance contract, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; a summary of the applicable issues, including a statement of our decision; the criteria used and clinical reasons for our decision; and the relevant portions of our review agent's utilization review guidelines. We must also include the name and credentials of the health care provider who reviewed and upheld the denial at the earlier appeal levels.

Within two (2) business days of receiving this information, the Director must send all the submitted information to an external independent reviewer organization (the "IRO").

Within seventy-two (72) hours of receiving the information, the IRO must make a decision and send the decision to the Director.

Within one (1) business day of receiving the IRO's decision, the Director must send a notice of the decision to us, our review agent, you and your treating provider.

**The decision (medical necessity):** If the IRO decides that we should provide the service, we must authorize the service. If the IRO agrees with our decision to deny the service, the appeal is over. Your only further option is to pursue your claim in Superior Court.

### **Contract Coverage Cases**

Within one (1) business day of receiving your request, we must:

- A. Send a written acknowledgment of your request to the Director, you, and your treating provider.
- B. Send the Director: the request for review; a copy of your insurance contract, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; a summary of the applicable issues, including a statement of our decision; and the criteria used and any clinical reasons for our decision.

Within two (2) business days of receiving this information, the Director must determine if the service or claim is covered, issue a decision, and send a notice to us, you, and your treating provider.

**Referral to the IRO for Contract Coverage Cases:** The Director is sometimes unable to determine issues of coverage. If this occurs, the Director will forward your case to an IRO. The IRO will have seventy-two (72) hours to make a decision and send it to the Director. The Director will have one (1) business day after receiving the IRO's decision to send the decision to us, you, and your treating provider.

**The decision (contract coverage):** If you disagree with the Director's final decision on a contract coverage issue, you may request a hearing with the Office of Administrative Hearings ("OAH"). If we disagree with the Director's final decision, we may also request a hearing before OAH. A hearing must be requested within 30 days of receiving the Director's decision. OAH must promptly schedule and complete a hearing for appeals from expedited Level 3 decisions.

## **STANDARD APPEAL PROCESS FOR NON-URGENT SERVICES AND DENIED CLAIMS**

### **Level 1 – Informal Reconsideration**

**Your request:** You may obtain Informal Reconsideration of your denied request for a service if:

- A. You have coverage with us;
- B. We denied your request for a covered service;
- C. You do not qualify for an expedited appeal; and
- D. You or your treating provider asks for Informal Reconsideration within two (2) years of the date we first deny the requested service by calling, writing, or faxing your request to:

Grievance Administrator  
PO Box 31371  
Salt Lake City, UT 84131-0371  
Phone: (800) 657-8205  
Fax: (801) 478-5463

**Claim for a covered service already provided but not paid for:** You may not obtain Informal Reconsideration of your denied request for the payment of a covered service. Instead, you may start the review process by seeking Formal Appeal.

**Our acknowledgment:** We or our review agent have five (5) business days after we receive your request for Informal Reconsideration (“the receipt date”) to send you and your treating provider a notice that we received your request.

**Our decision:** We or our review agent have thirty (30) days after the receipt date to decide whether we should change the decision and recommend the requested service. Within that same thirty (30) days, we or our review agent must send you and your treating provider the written decision. The written decision must explain the reasons for our decision and tell you the documents on which we or our review agent based the decision.

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| <b>If we deny your request:</b>          | You have sixty (60) days to appeal to Level 2.   |
| <b>If we grant your request:</b>         | We will recommend the service and the appeal is over.  |
| <b>If we refer your case to Level 3:</b> | We may decide to skip Level 1 and Level 2 and send your case straight to an independent reviewer at Level 3. |

### **Level 2 – Formal Appeal**

**Your request:** You may request Formal Appeal if:

- A. We deny your request at Level 1; or
- B. You have an unpaid claim and we did not provide a Level 1 review.

After you receive our Level 1 denial, you or your treating provider must send us a written request within sixty (60) days to tell us you are appealing to Level 2. If we did not provide a Level 1 review of your denied claim, you have two (2) years from our first denial notice to request Formal Appeal. To help us make a decision on your appeal, you or your provider should also send us any more information (that you have not already sent us) to show why we should authorize the requested service or pay the claim. Send your appeal request and information to:

Grievance Administrator  
PO Box 31371  
Salt Lake City, UT 84131-0371  
Phone: (800) 657-8205  
Fax: (801) 478-5463

**Our acknowledgment:** We have five (5) business days after we receive your request for Formal Appeal (“the receipt date”) to send you and your treating provider a notice that we received your request.

**Our decision:** For a denied service that you have not yet received, we or our review agent have thirty (30) days after the receipt date to decide whether we should change our decision and recommend the requested service. For denied claims, we have sixty (60) days to decide whether we should change our decision and pay your claim. We will send you and your treating provider our decision in writing. The written decision must explain the reasons for our decision and tell you the documents on which we based our decision.

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| <b>If we deny your request:</b>          | You have four (4) months to appeal to Level 3.   |
| <b>If we grant your request:</b>         | We will recommend the service and pay the claim and the appeal is over.                          |
| <b>If we refer your case to Level 3:</b> | We may decide to skip Level 2 and send your case straight to an independent reviewer at Level 3. |

### **Level 3 – External Independent Review**

**Your request:** You may appeal to Level 3 only after you have appealed through Levels 1 and 2. You have four (4) months after you receive our Level 2 decision to send us your written request for External Independent Review. Send your request and any more supporting information to:

Grievance Administrator  
PO Box 31371  
Salt Lake City, UT 84131-0371  
Phone: (800) 657-8205  
Fax: (801) 478-5463

Neither you nor your treating provider is responsible for the cost of any external independent review.

**The process:** There are two types of Level 3 appeals, depending on the issues in your case:

A. **Medical Necessity**

These are cases where we have decided not to recommend a service because we think the services you (or your treating provider) are asking for are not medically necessary to treat your problem. For medical necessity cases, the independent reviewer is a provider retained by an outside independent review organization (“IRO”) that is procured by the Arizona Department of Insurance and Financial Institutions and not connected with our company. For medical necessity cases, the reviewer must be a provider who typically manages the condition under review.

B. **Contract Coverage**

These are cases where we have denied coverage because we believe the requested service is not covered under your insurance plan. For contract coverage cases, the Arizona Department of Insurance and Financial Institutions is the independent reviewer.

### **Medical Necessity Cases**

Within five (5) business days of receiving your request, we must:

- A. Send a written acknowledgment of the request to the Director, you, and your treating provider.
- B. Send the Director: the request for review; a copy of your insurance contract, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; a summary of the applicable issues including a statement of our decision; the criteria used and clinical reasons for our decision; and the relevant portions of our review agent’s utilization review guidelines. We must also include the name and credentials of the health care provider who reviewed and upheld the denial at the earlier appeal levels.

Within five (5) days of receiving our information, the Director must send all the submitted information to an external independent review organization (“IRO”).

Within twenty-one (21) days of receiving the information, the IRO must make a decision and send the decision to the Director.

Within five (5) business days of receiving the IRO’s decision, the Director must send a notice of the decision to us, you, and your treating provider.

**The decision (medical necessity):** If the IRO decides that we should recommend the service or pay the claim, we must authorize the service or pay the claim. If the IRO agrees with our decision to deny the service or payment, the appeal is over. Your only further option is to pursue your claim in Superior Court.

### **Contract Coverage Cases**

Within five (5) business days of receiving your request, we must:

- A. Send a written acknowledgment of your request to the Director, you, and your treating provider.
- B. Send the Director: the request for review; a copy of your insurance contract, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; a

summary of the applicable issues including a statement of our decision; and the criteria used and any clinical reasons for our decision.

Within fifteen (15) business days of receiving this information, the Director must determine if the service or claim is covered, issue a decision, and send a notice to us, you, and your treating provider. If the Director decides that we should provide the service or pay the claim, we must do so.

### **Referral to the IRO for Contract Coverage Cases:**

The Director is sometimes unable to determine issues of coverage. If this occurs, the Director will forward your case to an IRO. The IRO will have twenty-one (21) days to make a decision and send it to the Director. The Director will have five (5) business days after receiving the IRO's decision to send the decision to us, you, and your treating provider.

**The decision (contract coverage):** If you disagree with the Director's final decision on a coverage issue, you may request a hearing with the Office of Administrative Hearings ("OAH"). If we disagree with the Director's determination of coverage issues, we may also request a hearing at OAH. Hearings must be requested within thirty (30) days of receiving the coverage issue determination. OAH has rules that govern the conduct of their hearing proceedings.

### **Obtaining Medical Records**

Arizona law (A.R.S. §12-2293) permits you to ask for a copy of your medical records. Your request must be in writing and must specify who you want to receive the records. The health care provider who has your records will provide you or the person you specified with a copy of your records.

**Designated Decision Maker:** If you have a designated health care decision maker, that person must send a written request for access to or copies of your medical records. The medical records must be provided to your health care decision maker or a person designated in writing by your health care decision maker unless you limit access to your medical records only to yourself or your health care decision maker.

**Confidentiality:** Medical records disclosed under A.R.S. §12-2293 remain confidential. If you participate in the appeal process, the relevant portions of your medical records may be disclosed only to people authorized to participate in the review process for the medical condition under review. These people may not disclose your medical information to any other people.

### **Documentation for an Appeal**

If you decide to file an appeal, you must give us any material justification or documentation for the appeal at the time the appeal is filed. If you gather new information during the course of your appeal, you should give it to us as soon as you get it. You must also give us the address and phone number where you can be contacted. If the appeal is already at Level 3, you should also send the information to the Department.

### **The Role of the Department of Insurance and Financial Institutions**

Arizona law (A.R.S. §20-2533(F)) requires "any member who files a complaint with the Department relating to an adverse decision to pursue the review process prescribed" by law. This means that, for appealable decisions, you must pursue the health care appeals process before the Director can investigate a complaint you may have against our company based on the decision at issue in the appeal.

The appeal process requires the Director to:

- A. Oversee the appeals process.
- B. Maintain copies of each utilization review plan submitted by insurers.
- C. Receive, process, and act on requests from an insurer for External Independent Review.
- D. Enforce the decisions of insurers.
- E. Review decisions of insurers.

- F. Send, when necessary, a record of the proceedings of an appeal to Superior Court or to the Office of Administrative Hearings (OAH).
- G. Issue a final administrative decision on coverage issues, including the notice of the right to request a hearing at OAH.

**Receipt of Documents**

Any written notice, acknowledgment, request, decision or other written document that is sent by mail is deemed received by the person to whom the document is properly addressed on the fifth business day after mailing. "Properly addressed" means your last known mailing address.





A UnitedHealthcare Company

For information on how or where to send this form, please refer to the Arizona Appeal Information Packet.

**HEALTH CARE APPEAL REQUEST FORM**

***You may use this form to tell your insurer you want to appeal a denial decision.***

Insured Member's Name \_\_\_\_\_ Member ID # \_\_\_\_\_  
Name of representative pursuing appeal, if different from above \_\_\_\_\_  
Mailing Address \_\_\_\_\_ Phone # \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Type of Denial:     Denied Claim                       Denied Service Not Yet Received

Name of Insurer that denied the claim/service: \_\_\_\_\_

If you are appealing your insurer's decision to deny a service you have not yet received, will a 30 to 60 day delay in receiving the service likely cause a significant negative change in your health? If your answer is "Yes," you may be entitled to an expedited appeal. Your treating provider must sign and send a certification and documentation supporting the need for an expedited appeal.

What decision are you appealing? \_\_\_\_\_

\_\_\_\_\_

*(Explain what you want your insurer to authorize or pay for.)*

Explain why you believe the claim or service should be covered:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*(Attach additional sheets of paper, if needed.)*

If you have questions about the appeals process or need help to prepare your appeal, you may call the Department of Insurance Consumer Assistance number (602) 364-2499 or (800) 325-2548, or Golden Rule Insurance Company at (800) 657-8205.

**Make sure to attach everything that shows why you believe your insurer should cover your claim or authorize a service, including:**  Medical records     Supporting documentation (letter from your doctor, brochures, notes, receipts, etc.). **\*\*Also attach the certification from your treating provider if you are seeking expedited review.**

\_\_\_\_\_  
Signature of insured or authorized representative

\_\_\_\_\_  
Date

## PROVIDER CERTIFICATION FORM FOR EXPEDITED MEDICAL REVIEWS

*(You and your provider may use this form when requesting an expedited appeal.)*

**A patient who is denied authorization for a covered service is entitled to an expedited appeal if the treating provider certifies and provides supporting documentation that the time period for the standard appeal process (about 60 days) “is likely to cause a significant negative change in the [patient’s] medical condition at issue.”**

### PROVIDER INFORMATION

Treating Physician/Provider \_\_\_\_\_  
Phone # \_\_\_\_\_ FAX # \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

### PATIENT INFORMATION

Patient's Name \_\_\_\_\_ Member ID # \_\_\_\_\_  
Phone # \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

### INSURER INFORMATION

Insurer Name \_\_\_\_\_  
Phone # \_\_\_\_\_ FAX # \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

- Is the appeal for a service that the patient has already received?  Yes  No  
If “Yes,” the patient must pursue the standard appeals process and cannot use the expedited appeals process. If “No,” continue with this form.
- What service denial is the patient appealing? \_\_\_\_\_  
\_\_\_\_\_
- Explain why you believe the patient needs the requested service and why the time for the standard appeal process will harm the patient. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Attach additional sheets if needed, and include:**  Medical records  Supporting documentation.

If you have questions about the appeals process or need help regarding this certification, you may call the Department of Insurance Consumer Assistance number (602) 364-2499 or (800) 325-2548. You may also call Golden Rule Insurance Company at (800) 657-8205.

I certify, as the patient’s treating provider, that delaying the patient’s care for the time period needed for the informal reconsideration and formal appeal processes (about 60 days) is likely to cause a significant negative change in the patient’s medical condition at issue.

Provider’s Signature \_\_\_\_\_ Date \_\_\_\_\_