EXTERNAL APPEAL PROCESS

If Health New England (HNE) has denied your claim or request for service, you may have the right to appeal. In addition, for members who have HMO and Advantage plans, an external appeal process may be available from the Massachusetts Department of Public Health, Office of Patient Protection (OPP). (This process does not apply to HNE Select Exclusive or Select Preferred Plans.)

If HNE has denied your clinical appeal and issued a Final Adverse Determination, you can ask for a non-HNE, external appeal. To do so, you need to file a written request with the OPP. HNE will provide you with the necessary filing forms when it notifies you of its final decision. You can also obtain the necessary forms by calling OPP or accessing its web site. The fee for filing an appeal is $25. This fee may be waived by OPP if it determines that the payment of the fee would result in an extreme financial hardship to the Member. Information on contacting OPP is at the end of this section. You must submit the request within 45 days after you receive HNE's final decision on your appeal.

The OPP will screen appeal requests. The OPP screening determines whether the request complies with OPP's requirements for external review requests (such as the $25 filing fee), whether the request involves a service or benefit that has been explicitly excluded from coverage, and whether the request is the result of a final Adverse Determination. Requests that pass the screening are sent to an independent review panel chosen by OPP. If the service or treatment you are requesting is a Covered Benefit, the appeal panel will decide if it is Medically Necessary. The panel will notify you and HNE of its decision within 60 business days of receipt of the request for review, unless it determines that it needs additional time. The panel may extend the time by an additional 15 business days. Your doctor can ask the panel to decide more quickly (an expedited review). If the panel agrees, it will decide within five business days. The decision of the review panel is final and binding.

If the subject of the external review involves the termination of ongoing services, you may ask the external review panel to continue coverage for the terminated service while the review is pending. Any such request must be made before the end of the second business day following receipt of the final adverse determination. The review panel may allow your request if it determines that substantial harm to your health may result without such continuation or for such other good cause as the review panel will determine. Any such continuation of coverage will be at HNE's expense regardless of the final external review decision.

How to contact the Office of Patient Protection:

- **Toll-free telephone:** 800-436-7757
- **Fax:** 617-624-5046
- **Web site:** state.ma.us/dph/opp

FINAL ADVERSE DETERMINATIONS

Remember, an external appeal is only available following a clinical appeal that is denied by HNE. This is called a "Final Adverse Determination." An "adverse determination" is a decision by HNE, based upon a review of information provided, to deny, reduce, modify or terminate health care services for failure to meet the requirements of coverage based on medical necessity, appropriateness of health care setting and level of care, or effectiveness. When the HNE formal internal grievance or appeal process is completed for an "adverse determination," it becomes a "final" adverse determination.