HMAA
HAWAII MEDICAL ASSURANCE ASSOCIATION

Appeals Procedure

Writing Us to Request an Appeal

If you wish to dispute a decision made by HMAA related to coverage, reimbursement, this Agreement, or any other decision or action by HMAA you must ask for an appeal. Your request must be in writing unless you are asking for an expedited appeal. We must receive it within one year from the date of the action or decision you are contesting. In the case of coverage or reimbursement disputes, this is one year from the date we first informed you of the denial or limitation of your claim, or of the denial of coverage for any requested service or supply.

Send written requests to:
HMAA, Attn: Appeals Coordinator
737 Bishop Street, Suite 1200
Honolulu, HI 96813
Or, send us a fax at (808) 591-0463

And, provide the information described in the section below labeled "What Your Request Must Include." Requests that do not comply with the requirements of this chapter will not be recognized or treated as an appeal by us.

If you have any questions about appeals, please contact our Customer Service Center.

Appeal of Our Precertification Decision

We will respond to your appeal as soon as possible given the medical circumstances of your case. It will be within 30 days after we receive your appeal.

Appeal of Any Other Decision or Action

We will respond to your appeal within 60 calendar days after we receive your appeal.

Expedited Appeal

You may ask for an expedited appeal if the time periods for appeals above may:

- Seriously risk your life or health,
- Seriously risk your ability to gain maximum functioning, or
- Subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal.

You may request expedited external review of our initial decision if you have requested an expedited internal appeal and the adverse benefit determination involves a medical condition for which the completion of an expedited internal appeal would meet the requirements above. The process for requesting an expedited external review is discussed below. You may ask for an expedited appeal by calling us at the phone number listed on the front cover of this DOC.

We will respond to your request for expedited appeal as soon as possible taking into account your medical condition. It will be no later than 72 hours after all information sufficient to make a determination is provided to us.

Who Can Request an Appeal

Either you or your authorized representative may ask for an appeal. Authorized representatives include:

- Any person you authorize to act on your behalf as long as you follow our procedures. This includes filing a form with us. To get a form to authorize a person to act on your behalf, please visit our website or call our Customer Service Center. (Requests for appeal from an authorized representative who is a physician or practitioner must be in writing unless you are asking for an expedited appeal.)
- A court-appointed guardian or an agent under a health care proxy.
- A person authorized by law to provide substituted consent for you or to make health care decisions on your behalf.
- A family member or your treating health care professional if you are unable to provide consent.

What Your Request Must Include

To be recognized as an appeal, your request must include all of this information:

- The date of your request.
- Your name and telephone number (so we may contact you).
- The date of the service we denied or date of the contested action or decision.
- For precertification for a service or supply, it is the date of our denial of coverage for the service or supply.
- The subscriber ID number from your member card.
- The provider name.
- A description of facts related to your request and why you believe our action or decision was in error.

- Any other details about your appeal. This may include written comments, documents, and records you would like us to review.

You should keep a copy of the request for your records. It will not be returned to you.

Information Available From Us

If your appeal relates to a claim for benefits or request for precertification, we will provide upon your request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to your claim as defined by the Employee Retirement Income Security Act.

If our appeal decision denies your request or any part of it, we will provide an explanation, including the specific reason for denial, reference to the health plan terms on which our decision is based, a statement of your external review rights, and other information regarding our denial.

If You Disagree with Our Appeal Decision

If you are enrolled in a group plan and you would like to appeal HMAA's decision, you must do one of the following:

- Request review by an Independent Review Organization (IRO), selected by the Insurance Commissioner if you are appealing an issue of medical necessity, appropriateness, health care setting, level of care, or effectiveness; or a determination by HMAA that the service or treatment is experimental or investigational;
- For all other issues:
    - File a lawsuit against HMAA under 29 USC 1132(a) unless your plan is one of the three bulleted types below in which case you must request arbitration before a mutually selected arbitrator:
        - A church plan as defined in 29 USC 2002(33) and no selection has been made in accord with 26 USC 410(d), or
        - A governmental plan as defined in 29 USC 1002(32).
        - A sole proprietor

Request Review by an Independent Review Organization (IRO) Selected by the Insurance Commissioner

If you choose review by an IRO, you must submit your request to the Insurance Commissioner within 130 days of HMAA's decision on appeal to deny or limit the service or supply.

Unless you qualify for expedited external review of our appeal decision, before requesting review, you must have exhausted HMAA's internal appeals process or show that HMAA violated federal rules related to claims and appeals unless the violation was 1) de minimis; 2) non-prejudicial; 3) attributable to good cause or matters beyond HMAA's control; 4) in the context of an ongoing good-faith exchange of information; and 5) not reflective of a pattern or practice of noncompliance.

Your request must be in writing and include:

- A copy of HMAA's final internal appeal decision.
- A completed and signed authorization form releasing your medical records relevant to the subject of the IRO review. A copy of the authorization form is available on our website or by calling our Customer Service Center.
- A complete and signed conflict of interest form. Copies of the conflict of interest form are available on our website or by calling our Customer Service Center.
- A check for $15.00 made out to the Insurance Commissioner. It will be refunded to you if the IRO overturns HMAA's decision. You are not required to pay more than $60.00 in any calendar year.

You must send the request to the Insurance Commissioner at:

State of Hawaii Insurance Division
Attn: Health Insurance Branch — External Appeals
335 Merchant Street, Room 213
Honolulu, HI 96813
Telephone (808) 586-2804

You will be informed by the Insurance Commissioner within 14 business days if your request is eligible for external review by an IRO.

You may submit additional information to the IRO. It must be received by the IRO within 5 business days of your receipt of notice that your request is eligible. Information received after that date will be considered at the discretion of the IRO.

The IRO will issue a decision within 45 calendar days of the IRO's receipt of your request for review.

The IRO decision is final and binding except to the extent HMAA or you have other remedies available under applicable federal or state law.

Expedited IRO Review

You may request expedited IRO review if:

- You have requested an expedited internal appeal at the same time and the timeframe for completion of an expedited internal appeal would seriously jeopardize your life, health, or ability to gain maximum functioning or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the adverse determination;
- The timeframe for completion of a standard external review would seriously jeopardize your life, health, or ability to gain maximum functioning, or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the adverse determination; or
- If the final adverse determination concerns an admission, availability of care, continued stay, or healthcare service for which you received emergency services; provided you have not been discharged from a facility for health care services related to the emergency services.

Expedited IRO review is not available if the treatment or supply has been provided.

The IRO will issue a decision as expeditiously as your condition requires but in no event more than 72 hours after the IRO's receipt of your request for review.

External Review of Decisions Regarding Experimental or Investigational Services

You may request IRO review of an HMAA determination that the supply or service is experimental or investigational. Your request may be oral if your treating physician certifies, in writing, that the treatment or supply would be significantly less effective if not promptly started.

Written requests for review must include, and oral requests must be promptly followed up with, the same documents described above for standard IRO review plus a certification from your physician that:

- Standard health care services or treatments have not been effective in improving your condition;
- Standard health care services or treatments are not medically appropriate for you; or
- There is no available standard health care service or treatment covered by your plan that is more beneficial than the health care service or treatment that is the subject of the adverse action.

Your treating physician must certify in writing that the service recommended is likely to be more beneficial to you, in the physician's opinion, than any available standard health care service or treatment, or your licensed, board certified or board eligible physician must certify in writing that scientifically valid studies using accepted protocols demonstrate the service that is the subject of the external review is likely to be more beneficial to you than any available standard health care services or treatment.

The IRO will issue a decision as expeditiously as your condition requires but in no event more than 7 calendar days of the IRO's receipt of your request for review.

Request Arbitration

If you are eligible for and choose arbitration, you must submit a written request for arbitration to HMAA, 737 Bishop Street, Suite 1200, Honolulu, Hawaii 96813. Your request for arbitration will not affect your rights to any other benefits under this plan. You must have fully complied with HMAA's appeals procedures described above and we must receive your request for arbitration within one year of the decision rendered on appeal. In arbitration, one person (the arbitrator) reviews the positions of both parties and makes the final decision to resolve the issue. No other parties may be joined in the arbitration. The arbitration is binding and the parties waive their right to a court trial and jury.

Before arbitration starts, both parties (you and we) must agree on the person to be the arbitrator. If we both cannot agree within 30 days of your request for arbitration, either party may ask the First Circuit Court of the State of Hawaii to appoint an arbitrator.

The arbitration hearing shall be in Hawaii. The rules of the arbitration shall be those of the Dispute Prevention and Resolution, Inc. to the extent not inconsistent with this *Chapter 8: Dispute Resolution.* The arbitration shall be conducted in accord with the Federal Arbitration Act, 9 U.S.C. §1 et seq., and such other arbitration rules as both parties agree upon.

The arbitrator will make a decision as quickly as possible and will give both parties a copy of this decision. The decision of the arbitrator is final and binding. No further appeal or court action can be taken except as provided under the Federal Arbitration Act.

HMAA will pay the arbitrator’s fee. You must pay your attorney's or witness's fees, if you have any, and we must pay ours. The arbitrator will decide who will pay all other costs of the arbitration.

HMAA waives any right to assert that you have failed to exhaust administrative remedies because you did not select arbitration.