

For More Information

State of Tennessee
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THE APPEALS PROCESS

an explanation of the
right to appeal claim
decisions for participants
in the state group
insurance program

Claims Appeal

Before initiating a claims-related appeal, you should first contact the insurance company (claims administrator) to get an explanation of the claims payment. If you are unable to resolve your issue, you may then request an appeal.

Appealing to the Claims Administrator

If you are in disagreement with a decision or the way a claim has been paid or processed, you or your authorized representative should first call member services to discuss the issue. If the issue cannot be resolved through member services, you may file a formal request for review or member grievance by completing the appropriate form or as otherwise instructed. All requests must be filed within the specified time frame. When your request for review or member grievance is received, you will get an acknowledgement letter advising you what to expect regarding the processing of your grievance. When a determination is made, you will be notified in writing and advised of any further appeal options.

Mental Health and Substance Abuse Appeals

In most instances, mental health claims and medical claims are handled by different companies. To expedite your appeal for mental health and/or substance abuse services, make sure that you contact the company handling your mental health claims by calling their customer service number. A representative will

provide you with an address for submitting an appeal. You should complete all levels of appeal through your mental health carrier's appeal process. If your appeal is denied at the final level, you may then appeal to the plan administrator, Benefits Administration.

Administrative Review

You may also request a review of administrative issues, including certain decisions made on behalf of the Plans. To request this type of review, provide your agency benefits coordinator with a letter detailing the circumstances of your situation. The benefits coordinator will forward your letter to Benefits Administration. Your correspondence will be reviewed, and you will receive a written response to your request.

Appealing to the Plan Administrator

Benefits Administration has an appeal process that is available to you **after** you have exhausted the grievance process with the claims administrator. Appeals must be requested in writing within two years of the claim determination or decision. To file an appeal at the state level, the member should send a letter and supporting documentation (e.g., explanation of benefit statements, decision letters, statements from healthcare providers and medical records) to Benefits Administration. The address can be found on the back of this brochure.

It's a good idea to maintain a copy of all correspondence you send. Specific questions regarding the ap-



peal process may be directed to the appeals coordinator for the state.

It is very important that you provide a phone number or email address where you can be reached during business hours so that you can be contacted with questions or information about your appeal.

Appeal Review

The appeals coordinator in Benefits Administration will thoroughly review all information submitted to determine the exact nature of the appeal. The majority of requests for appeal require additional review by the claim administrator. The average review takes approximately 60 days to complete. Some cases may require additional time for review depending on individual circumstances. Some cases may also require review by the state's independent medical consultant.

If consideration of your appeal does not result in a satisfactory resolution, the appeals coordinator may schedule it for additional review by the Insurance Appeals Staff Review Committee. The determination to request such a review will be made by the appeals coordinator in Benefits Administration.

Staff Review Committee

The Staff Review Committee is composed of employees within state government selected by the Insurance Committees. The Staff Review Committee meets once a month to review ap-

peals that have not been resolved. Prior to the Staff Review Committee meeting, you will be furnished with a copy of your case file and will have the opportunity to notify Benefits Administration if you feel that any information in the file is incorrect or incomplete. You may make a personal presentation to the Staff Review Committee, or your appeal can be reviewed based on the written record. After the Staff Review Committee has heard your appeal, their votes are tallied, and the results are forwarded to the Insurance Appeals Sub-Committee.

Appeals Sub-Committee

The Appeals Sub-Committee consists of selected State Insurance Committee members. This committee receives a written report of each appeal and is advised of the recommendation from the Staff Review Committee's meeting. After reviewing the written appeals, each Sub-Committee member votes individually by written ballot and returns the ballot to the appeals coordinator in Benefits Administration. If the majority of the Sub-Committee votes that they agree with the decision of the Staff Review Committee, the decision will stand. If, however, the majority of the Sub-Committee votes for an additional review of the case, it will be scheduled for presentation at a second meeting.

If your appeal is scheduled for a second meeting, you will again be given the opportunity to make a personal presentation. You may make a personal pre-

sentation at this level even if you did not appear at the first meeting, or your case can be reviewed on the written record.

You will receive written notification of the outcome of your appeal after all the Insurance Appeals Sub-Committee votes have been returned. It normally takes about two weeks (from the date of the first appeals meeting). The decision of the Insurance Appeals Sub-Committee is final and is the last step in the administrative appeals process.

Pursuing Further Action

If an appeal is denied by both the Staff Review Appeals Committee and the Insurance Appeals Sub-Committee, state and local education employees may take further action. Along with the notification of the decision on your appeal, you will receive information about contacting the Tennessee Division of Claims in the Department of Treasury. Local government employees may take further action through independent legal counsel.

Once you have filed a claim with the Department of Treasury, the State Attorney General's Office will be notified of your claim for damages. The following is an outline of guidelines followed by the Attorney General's office once your claim for money damages is received in their office.

Regardless of whether you choose to present your claim at a hearing or by affidavit, you must produce competent evidence in support of your claim. You have the burden of proof.

Hearing

You may request a hearing from the claims commissioner. At the hearing, you will be given the opportunity to present evidence to support your claim for money damages against the state. An assistant attorney general will present evidence to the contrary. The hearing will be conducted like cases in General Sessions Court. Based upon the evidence presented at this hearing, the claims commissioner will rule on your claim.

Affidavit

This is a sworn statement by you and/or any witness in support of your claim. An affidavit must be sworn to before a notary public. If you want to have your claim decided by affidavit without a hearing, you must sign an Agreed Order of Waiver of Hearing. A claims commissioner will sign the order, and copies will be sent to you and the undersigned assistant attorney general. When you receive a copy of the order, you should file any affidavits in support of your claim in accordance with the schedule set forth in the order. Once all the affidavits are filed, the claims commissioner will decide the claim based only upon those affidavits.