ASEA/AFSCME LOCAL 52 HEALTH BENEFITS TRUST

Policy on
Appeal of Denied Claims Involving Medical Necessity

Upon receipt by the claims administrator of a second-tier appeal to the Board of Trustees of the denial of a benefit claim based upon a determination by the contracted utilization review organization that the health treatment, service or device was not "medically necessary," the claims administrator shall, as a matter of course, request a second independent review of the claim by a qualified independent medical review organization on the issue of medical necessity. The claims administrator shall notify the appellant in writing that the Trust is seeking a second independent review of medical necessity, and that the appeal will be scheduled to be heard by the Board of Trustees at its next regularly scheduled meeting following receipt of the second independent review report.

The claims administrator's notice to the appellant shall advise that the appellant has the opportunity to submit any additional evidence that they have or can obtain to support their position that the treatment, health service, or device was medically necessary, provided such information is received by the claims administrator within ten (10) days of the date of the notice. If the appellant requires a reasonable extension of time to compile the additional evidence that they intend to submit to the second independent reviewer, the appellant may request a reasonable extension, not to exceed sixty (60) days, provided the request for such an extension is received within ten (10) days of the date of the notice.

The claims administrator shall provide any additional evidence received from the appellant to the second independent medical reviewer for consideration. When transmitting any information, including any additional evidence received from the appellant, to the second independent reviewer for consideration, the claims administrator shall not include the results of the first independent medical review.

If the second independent review report upholds the claims administrator's denial of the claim as not medically necessary, then the appellant will be advised of—

1. the results of the second review;

2. the date of the next regularly scheduled Board of Trustees meeting at which the appeal will be heard;

3. the opportunity for the appellant to appear in person, or telephonically;

4. and/or, the appellant's right to be represented by counsel or a representative of their choosing at such hearing.

If the second independent review results support a finding of medical necessity, the claims administrator shall advise the appellant in writing that the claim has been approved and shall cover the claim under the terms of the Plan.

This Policy is adopted this December 9th, 2004, replaces any previously adopted versions, and is effective until revoked, revised, or amended.

Fred G. Brown, Trustee

Chris Pace, Trustee

Michael Williams, Trustee

Frank Puschak, Trustee

Stanley Kaneshiro, Trustee

Patricia Nault, Trustee