BEHAVIORAL HEALTHCARE PROVIDERS

External Appeal Information – BHP Managed Plans

BHP complies with all regulatory guidelines and responsibilities as established in MN statute 62Q.73. BHP contracted managed health plans are responsible for informing all enrollees of the right to an external appeal in their member communication materials. External appeal rights are specific to the details of the managed health plan; some health plans are exempt from external appeal rights through the state of MN.

External Appeal Rights – Department of Commerce

An external review organization is an independent entity under contract with the State of Minnesota to review health plan appeals. If you or someone acting on your behalf has exhausted, or is deemed to have exhausted the internal appeals processes, you or your authorized representative may file a request for external review, along with your filing fee of $25*, as noted below, with the Minnesota Department of Commerce at the address below:

Minnesota Department of Commerce
Attention: Enforcement Division
85 East Seventh Place
Suite 500
St. Paul, MN 55101-2198

You are deemed to have exhausted the health plan's internal appeals processes, if the health plan waives the exhaustion requirement, the health plan fails to substantially comply with the requirements of this section or you request an expedited external review at the same time you qualify for and request an acute care service appeal.

If you want an external review, you must request it within six months after the date of the final denial determination.

Cases involving fraudulent marketing and agent misrepresentation are not eligible for external review. External review decisions are binding on the health plan, but are not binding on you. The fee for an external review is $25 and the maximum fee that you may be charged in one year for external reviews is $75.

*This fee may be waived due to hardship and will be refunded by the Minnesota Department of Commerce, its contracted external review organization, or its designee, if you prevail and the health plan's denial decision is completely reversed.

How to File a Complaint with the Minnesota Department of Commerce

You or someone acting on your behalf may file a complaint with the Minnesota Department of Commerce at any time. You may reach the Minnesota Department of Commerce at 651.539.1600 within the Twin Cities metropolitan area or by calling 1.800.657.3602 from outside the Twin Cities.

External Appeal Rights – PreferredOne Self-Funded Plans

If *your* request or *claim* is wholly or partially denied, reduced, or terminated based on medical judgment, as defined in the Affordable Care Act, or if *your* coverage is rescinded (retroactively terminated), as defined by the Affordable Care Act, *you* may have a right to have such decision reviewed by an independent review organization that is not associated with the *TPA*, *Plan* or *Plan Administrator*. The decision of the independent review organization is binding except to the extent other remedies may be available to the *Plan*, any person, or any entity under state or federal law. The following sections relating to Standard External Review and Expedited External Review shall apply only to a request or *claim* that is wholly or partially denied, reduced, or terminated based on medical judgment, as defined in the Affordable Care Act or if *your* coverage is rescinded (retroactively terminated), as defined by the Affordable Care Act."

1. **Standard External Review**. *You* may request an external review of any pre-service request or post-service *claim* if *you* have exhausted all appeals available to *you* under the internal appeals process. Any denial, reduction, or termination of, or failure to provide payment for, a *benefit* based on a determination that *you* failed to meet the requirements for eligibility under the terms of the *Plan* is not eligible for external review. Within four months after receiving a notice informing *you* of *your* right to an external review by an independent review organization, *you* or *your* authorized representative may submit a written request for an external review with an independent review organization by sending it to the *TPA*. When *you* request an external review, *you* will be required to authorize release of any medical records that the independent review organization might need to review for the purpose of reaching a decision.
Within one business day after completion of a preliminary review, which may take up to five business days, to confirm whether *you* were enrolled properly in the *Plan* at the time the pre-service *claim* was requested or postservice *claim* was provided, the *TPA* will notify *you* that *your* request is: a. Complete and eligible for external review; or
b. Not complete, and will indicate what additional information or materials are needed to make it complete; or
c. Not eligible for external review and the reasons for its ineligibility.

If *your* request is complete and eligible for external review, the *TPA* will notify *you* which independent review organization will conduct the external review. *You* will then receive more detailed information, including contact information for the independent review organization and the independent review process and timetable.

2. **Expedited External Review**. *You* may request an expedited external review if:
a. *Your* request for pre-certification of acute care services is wholly or partially denied and *you* have not received such services, or *you* are currently receiving acute care services and the continuation of these services is wholly or partially denied and the timeframe for completion of an expedited internal appeal would seriously jeopardize *your* life, health, or ability to regain maximum function. Nevertheless, *you* must have filed a request for an expedited internal appeal in order to request an expedited external review; or
b. *You* exhausted the internal appeals process and *you* have a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize *your* life, health, or ability to regain maximum function; or
c. *You* exhausted the internal appeals process for coverage that involves an admission, availability of care, continued stay or health care item or service for which *you* received *emergency* services but have not been discharged from a facility. When *you* request an external review, *you* will be required to authorize release of any medical records that the independent review organization might need to review for the purpose of reaching a decision. Immediately upon receipt of *your* request for an expedited external review, the *TPA* will make a determination and notify *you* that *your* request is:
- complete and eligible for external review; or
- not complete, and will indicate what information or materials are needed to make it complete; or
- not eligible for external review and the reasons for its ineligibility.

If *your* request is complete and eligible for the external review process, the *TPA* will notify *you* which independent review organization will conduct the external review. *You* will then receive more detailed information, including contact information for the independent review organization and the independent review process and timetable.