WMI Mutual Insurance Company ("WMI")
Health Care Appeals Process Information Packet

CAREFULLY READ THE INFORMATION IN THIS PACKET AND KEEP IT FOR FUTURE REFERENCE. IT HAS IMPORTANT INFORMATION ABOUT HOW TO APPEAL DECISIONS WE MAKE ABOUT YOUR HEALTH CARE.

Getting Information About the Health Care Appeal Process and Help in Filing an Appeal: Standardized Forms and Consumer Assistance From the Department of Insurance and Financial Institutions

We must send you a copy of this information packet when you first receive your policy, at your request or the request of your treating provider, and provide access to a copy of the information packet on our website. When your insurance coverage is renewed, we must also send you a separate statement to remind you that you can request another copy of this packet. Just call our claims department at (801) 263-8000 or (800) 748-5340 to request one.

At the back of this packet, you will find forms you can use for your appeal. The Arizona Department of Insurance and Financial Institutions ("the Department") developed these forms to help people who want to file a health care appeal. You are not required to use them. We cannot reject your appeal if you do not use them. If you need help filing an appeal, or you have questions about the appeals process, you may call the Department's Consumer Services Section at (602) 364-2499 or (800) 325-2548 (outside Phoenix), or you may call WMI at (801) 263-8000 or (800) 748-5340.

Types of Claims That Are Subject to the Appeals Process

There are two types of claims: pre-service and post-service. A "pre-service claim" is any claim for a benefit that is subject to pre-certification for which care has not already been provided. Pre-service claims involving urgent care are not required to be pre-certified. A "post-service claim" is any claim that involves the cost for medical care that has already been provided.

How to Know When You Can Appeal

When WMI does not pre-certify a service or pay for a claim, in whole or in part, we must notify you of your right to appeal that decision. Your notice may come directly from WMI, from the company that performs the pre-certifications, or through your treating provider.

Decisions You Can Appeal

You can appeal the following decisions:

1. We do not approve a service that you or your treating provider has requested.
2. We do not pay for a service that you have already received.

3. We do not pre-certify a service or pay for a claim because we say that it is not "medically necessary".
4. We do not pre-certify a service or pay for a claim because we say that it is not covered under your insurance policy, and you believe it is covered.
5. We do not notify you, within 10 business days of receiving your request, whether or not we will authorize a requested service.
6. We do not authorize a referral to a specialist.

Decisions You Cannot Appeal

You cannot appeal the following decisions:

1. You disagree with our decision as to the amount of "usual and customary" charges.
2. You disagree with how we are coordinating benefits when you have health insurance with more than one insurer.
3. You disagree with how we have applied your claims or services to your plan deductible.
4. You disagree with the amount of coinsurance or copayments that you paid.
5. You disagree with our decision to issue or not issue a policy to you.
6. You are dissatisfied with any rate increases you may receive under your insurance policy.
7. You believe we have violated any other parts of the Arizona Insurance Code.

If you disagree with a decision that is not appealable according to this list, you may still file a complaint with the Arizona Department of Insurance and Financial Institutions, Consumer Services Section, 100 North 15th Avenue, Suite 261, Phoenix, AZ 85007-2630. You can also file a complaint via their website: www.difi.az.gov.

Who Can File An Appeal?

Either you or your treating provider can file an appeal on your behalf. At the end of this packet is a form that you may use for filing your appeal. You are not required to use this form; you may send us a letter instead with the same information, along with any additional supporting documentation. If you decide to appeal the decision to deny a pre-service claim, you should tell your treating provider so the provider can help you with the information you need to present your case.

Description of the Appeals Process

There are two types of appeals: an expedited appeal for urgent matters, and a standard appeal. Each type of appeal has 3 levels. The appeals operate in a similar fashion, except that expedited appeals are processed much faster because of a patient's condition.

	Expedited Appeals (for urgently needed services you have not yet received)	**Standard Appeals** (for non-urgent services or denied claims)
Level 1.	Expedited Medical Review	Informal Reconsideration
Level 2.	Expedited Appeal	Formal Appeal
Level 3.	Expedited External Independent	External Independent Medical

Medical Review Review

MedWatch (refer to page 9) makes the Level 1 and Level 2 decisions for Expedited Appeals. WMI makes the Level 1 and Level 2 decisions for Standard Appeals, unless the appeal is based on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate. In that case, we will consult with an independent health care professional who has appropriate training and expertise in the field of medicine involved in the medical judgment. An outside reviewer, who is completely independent from our company, makes Level 3 decisions. You are not responsible to pay the costs of the external review if you choose to appeal to Level 3.

EXPEDITED APPEALS PROCESS FOR URGENTLY NEEDED SERVICES NOT YET PROVIDED

Level 1. Expedited Medical Review

Your request: You may obtain Expedited Medical Review of your denied pre-service claim for urgently needed services if:

- You have coverage with us,
- We denied your pre-service claim for urgently needed services, and
- Your treating provider certifies in writing and provides supporting documentation that the time to process your request through the Informal Reconsideration and Formal Appeal process (about 30 days) is likely to cause a significant negative change in your medical condition. (At the end of this packet is a form that your provider may use for this purpose. Your provider could also send a letter or make up a form with similar information.) Your treating provider must send the certification and supporting documentation to:

Name:	MedWatch
Address:	P.O. Box 952679, Lake Mary, FL 32795-2679
Phone:	(800) 432-8421
Fax:	(407) 333-8928

Our decision: We have 1 business day after we receive the information from the treating provider to decide whether we should change our decision and pre-certify your requested service. Within that same business day, we must call and tell you and your treating provider our decision, and mail you our decision in writing. The written decision must explain the reasons for our decision and identify the documents on which we based our decision.

If we deny your request: You may immediately appeal to Level 2.

If we grant your request: We will pre-certify the service and the appeal is over.

If we refer your case to Level 3: We may decide to skip Level 1 and Level 2 and send your case straight to an independent reviewer at Level 3.

Level 2. Expedited Appeal

Your request: If we deny your request at Level 1, you may request an Expedited Appeal. After you receive the Level 1 denial, your treating provider must immediately send a written request to the same entity and address listed above under Level 1 to tell us you are appealing to Level 2. To help your appeal, your provider should also send any additional information that hasn't already been sent, to show why you need the requested service.

Our decision: We have 3 business days after we receive the request to make our decision.

If we deny your request: You may immediately appeal to Level 3. If you decide not to appeal to Level 3 you have the right to file suit in court.

If we grant your request: We will pre-certify the service and the appeal is over.

If we refer your case to Level 3: We may decide to skip Level 2 and send your case straight to an independent reviewer at Level 3.

Level 3: Expedited External Independent Review

Your request: You may appeal to Level 3 only after you have appealed through Levels 1 and 2. You only have 5 business days after you receive the Level 2 decision to send your written request for Expedited External Independent Review. Send your request and any additional supporting information to the same entity listed above that was used for the Levels 1 and 2 appeals.

Neither you nor your treating provider is responsible for the cost of any external independent review.

The process: There are two types of Level 3 appeal depending on the issues in your case.

(1) Medical Necessity

These are cases where we have decided not to pre-certify a service because we think the services that you or your treating provider are asking for are not medically necessary to treat your problem. For medical necessity cases, the independent reviewer is a provider retained by an outside independent review organization ("IRO"), procured by the Arizona Department of Insurance and Financial Institutions, and not connected with our company. The IRO provider must be a provider who typically manages the condition under review.

(2) Contract coverage

These are cases where we have denied coverage because we believe that the requested service is not a covered benefit under your insurance policy. For contract coverage cases, the Arizona Department of Insurance and Financial Institutions is the independent reviewer.

Medical Necessity Cases

Within 1 business day of receiving your request, we must:

1. Send a written acknowledgement of the request to the Director of the Department of Insurance and Financial Institutions ("Director"), you, and your treating provider.

2. Send the Director: the request for review; your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; a summary of the applicable issue including a statement of our decision; the criteria used and clinical reasons for our decision; and the relevant portions of our utilization review guidelines. We must also include the name and credentials of the health care provider who reviewed and upheld the denial at the earlier appeal levels.

Within 2 business days of receiving our information, the Director must send all of the submitted information to an external IRO.

Within 72 hours of receiving the information the IRO must make a decision and send the decision to the Director.

Within 1 business day of receiving the IRO's decision, the Director must send a notice of the decision to us, you, and your treating provider.

The decision (medical necessity): If the IRO decides that we should pre-certify the service, we must do so. If the IRO agrees with our decision to deny the pre-certification, the appeal is over. Your only further option is to pursue your claim in Superior Court.

Contract Coverage Cases

Within 1 business day of receiving your request, we must:

1. Send a written acknowledgement of the request to the Director, you, and your treating provider.

2. Send the Director: the request for review; your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; a summary of the applicable issue including a statement of our decision; the criteria used and clinical reasons for our decision; and the relevant portions of our utilization review guidelines.

Within 2 business days of receiving this information, the Director must determine if the service is covered, issue a decision, and send a notice to us, you, and your treating provider.

Referral to the IRO for contract coverage cases: The Director is sometimes unable to determine issues of coverage. If this occurs, the Director will forward your case to an IRO. The IRO will have 72 hours to make a decision and send it to the Insurance Director. The Director will have 1 business day after receiving the IRO's decision to send the decision to us, you, and your treating provider.

The decision (contract coverage): If you disagree with the Director's final decision on a contract coverage issue, you may request a hearing with the Office of Administrative Hearings ("OAH"). If we disagree with the Director's final decision, we may also request a hearing before OAH. A hearing must be requested within 30 days of receiving the Director's decision. OAH must promptly schedule and complete a hearing for appeals from expedited Level 3 decisions.

STANDARD APPEAL PROCESS FOR NON-URGENT SERVICES AND DENIED CLAIMS

Level 1. Informal Reconsideration

Your request: You may request an Informal Reconsideration if you receive a denial on your pre-or post-service claim if:

- You have coverage with us,
- We denied your pre-service claim or your post-service claim,
- You do not qualify for an expedited appeal, and
- You or your treating provider asks for an Informal Reconsideration within 2 years of the date we first deny the pre-service claim or the post-service claim by calling, or sending your request to:

  Name: Corina Greenfield
  Title: Claims Manager
  Address: WMI Mutual Insurance Company, P.O. Box 572450, Salt Lake City, UT 84157
  Phone: (801) 263-8000
  Fax: (801) 263-1189

Our acknowledgment: We have 5 business days after we receive your request for an Informal Reconsideration ("the receipt date") to send you and your treating provider a notice that your request was received.

Our decision: For a denied pre-service claim, we have 15 calendar days after the receipt date to decide whether we should change our decision and pre-certify your requested service. For denied post-service claims, we have 30 calendar days to decide whether we should change our decision. We will send you and your treating provider our decision in writing. The written decision must explain the reasons for our decision and identify the documents on which we based our decision.

If we deny your Level 1 review: You have 60 calendar days to appeal to Level 2.

If we grant your appeal: We will pre-certify the service or pay the claim and the appeal is over.

If we refer your case to Level 3: We may decide to skip Level 1 and Level 2 and send your case straight to an independent reviewer at Level 3.

Level 2. Formal Appeal

Your request: You may request a Formal Appeal if you receive a denial on your Level 1 review. After you receive the Level 1 denial, you or your treating provider must send us a written request within 60 days to advise us that you are appealing to Level 2. To help us make a decision on your appeal, you or your provider should also send us any additional information that you haven't already sent us, to show why we should pre-certify the requested service or pay the claim. Send your appeal request and information to the same entity and address listed above under Level 1.

Our acknowledgment: We have 5 business days after we receive your request for Formal Appeal ("the receipt date") to send you and your treating provider a notice that your request was received.

Our decision: For a denied pre-service claim, we have 15 calendar days after the receipt date to decide whether we should change our decision and pre-certify your requested service. For a denied post-service claim, we have 30 calendar days to decide whether we should change our decision. We will send you and your treating provider our decision in writing. The written decision must explain the reasons for our decision and identify the documents on which we based our decision.

If we deny your Level 2 appeal: You have four months to appeal to Level 3. If you decide not to appeal to Level 3 you have the right to file suit in court.

If we grant your appeal: We will pre-certify the service or pay the claim and the appeal is over.

Level 3: External, Independent Review

(Note: Level 3 appeals cannot be accepted for issues regarding deductible amounts, co-insurance levels, or usual and customary allowed amounts)

Your request: You may appeal to Level 3 only after you have appealed through Levels 1 and 2. You have four months after you receive our Level 2 decision to send us your written request for External, Independent Review. Send your request and any additional supporting information to the appropriate entity listed above that was used for the Levels 1 and 2 appeals.

Neither you nor your treating provider is responsible for the cost of any external independent review.

The process: There are two types of Level 3 appeals, depending on the issues in your case:

(1) Medical Necessity

These are cases where we have decided not to pre-certify a service or we have denied a claim because we think the services that you or your treating provider are asking for, or the services that you have already received, are not medically necessary to treat your problem. For medical necessity cases, the independent reviewer is a provider retained by an outside independent review organization ("IRO"), procured by the Arizona Department of Insurance and Financial Institutions, and not connected with our company. For medical necessity cases, the provider must be a provider who typically manages the condition under review.

(2) Contract Coverage

These are cases where we have denied coverage because we believe that the requested service or the service already provided is not a covered benefit under your insurance policy. For contract coverage cases, the Arizona Department of Insurance and Financial Institutions is the independent reviewer.

Medical Necessity Cases

Within 5 business days of receiving your request, we must:

1. Mail a written acknowledgement of the request to the Insurance Director, you, and your treating provider.

2. Send the Director: the request for review; your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; a summary of the applicable issue including a statement of our decision; the criteria used and clinical reasons for our decision; and the relevant portions of our utilization review guidelines. We must also include the name and credentials of the health care provider who reviewed and upheld the denial at the earlier appeal levels.

Within 5 days of receiving our information, the Director must send all of the submitted information to an IRO.

Within 21 days of receiving the information the IRO must make a decision and send the decision to the Director.

Within 5 business days of receiving the IRO's decision, the Insurance Director must mail a notice of the decision to us, you, and your treating provider.

The decision (medical necessity): If the IRO decides that we should pre-certify the service or pay the claim, we must do so. If the IRO agrees with our decision to deny the pre-certification or claim, the appeal is over. Your only further option is to pursue your claim in Superior Court.

Contract Coverage Cases

Within 5 business days of receiving your request, we must:

1. Send a written acknowledgement of the request to the Insurance Director you, and your treating provider.

2. Send the Director: the request for review; your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; a summary of the applicable issue including a statement of our decision; the criteria used and clinical reasons for our decision; and the relevant portions of our utilization review guidelines.

Within 15 business days of receiving this information, the Director must determine if the pre-service or post-service claim is covered, issue a decision, and send a notice to us, you, and your treating provider. If the Director decides that we should provide the service or pay the claim, we must do so.

Referral to the IRO for contract coverage cases: The Director is sometimes unable to determine issues of coverage. If this occurs, the Insurance Director will forward your case to an IRO. The IRO will have 21 days to make a decision and send it to the Insurance Director. The Insurance Director will have 5 business days after receiving the IRO's decision to send the decision to us, you, and your treating provider

The decision (contract coverage): If you disagree with the Director's final decision on a coverage issue, you may request a hearing with the Office of Administrative Hearings ("OAH"). If we disagree with the Insurance Director's final decision on a coverage issue, we may also request a hearing with OAH. Hearings must be requested within 30 days of receiving the coverage issue determination. OAH has rules that govern the conduct of their hearing proceedings.

Obtaining Medical Records

Arizona law (A.R.S. §12-2293) permits you to ask for a copy of your medical records. Your request must be in writing and must specify who you want to receive the records. The health care provider who has your records will provide you or the person you specified with a copy of the records.

Designated Decision-Maker: If you have a designated health care decision-maker, that person must send a written request for access to or copies of your medical records. The medical records must be provided to your health care decision-maker or a person designated in writing by your health care decision-maker unless you limit access to your medical records only to yourself or your health care decision-maker.

Confidentiality: Medical records disclosed under A.R.S. §12-2293 remain confidential. If you participate in the appeal process, the relevant portions of your medical records may be disclosed only to people authorized to participate in the review process for the medical condition under review. These people may not disclose you medical information to any other people.

Documentation for an Appeal

If you decide to file an appeal, you must give us any material justification or documentation for the appeal at the time that the appeal is filed. If you gather new information during the course of your appeal, you should give it to us as soon as you get it. You must also give us the address and phone number where you can be contacted. If the appeal is already at Level 3, you should also send the information to the Department.

The Role of the Department of Insurance and Financial Institutions

Arizona law (A.R.S. §20-2533(F)) requires "any member who files a complaint with the Department relating to an adverse decision to pursue the review process prescribed" by law. This means, for decisions that can be appealed, you must pursue the health care appeals process before the Director can investigate a complaint you may have against our company based on the decision at issue in the appeal.

The appeal process requires the Director to:

1. Oversee the appeals process.
2. Maintain copies of each utilization review plan submitted by insurers.
3. Receive, process and act on requests from an insurer for External, Independent Review.
4. Enforce the decisions of insurers.
5. Review decisions of insurers.
6. Send, when necessary, a record of the proceedings of an appeal to Superior Court or to the Office of Administrative Hearings ("OAH").
7. Issue a final administrative decision on coverage issues, including the notice of the right to request a hearing at OAH.

Receipt of Documents

Any written notice, acknowledgment, request, decision or other written document that is sent by mail is deemed received by the person to whom the document is properly addressed on the fifth business day after being mailed. "Properly addressed" means your last known address.

WMI Mutual Insurance Company ("WMI")

P.O. Box 572450, Salt Lake City, Utah 84157-2450
Telephone: 801-263-8000 Toll Free: 800-748-5340
Claims Fax: 801-263-1189

Health Care Appeal Request Form

You may use this form to tell your insurer you want to appeal a denial decision

Insured Member's Name _____ Member ID# _____
Name of representative pursuing appeal, if different from above _____
Mailing Address _____
Street City State Zip
Phone # _____

Type of denial: [ ] Denied pre-service claim [ ] Denied post-service claim

If you are appealing the decision to deny a pre-service claim, will a 15 to 30 day delay in receiving the service likely cause a significant negative change in your health? If your answer is "Yes", you may be entitled to an expedited appeal. Your treating provider must sign and send a certification and documentation supporting the need for an expedited appeal.

What decision are you appealing? Please provide as much applicable information as possible such as claim number(s), name of provider, and dates of service._____

Explain why you think the claim should be eligible for benefits (attach additional sheets, if necessary)._____

If you have questions about the appeals process or need help to prepare your appeal, you may call the Department of Insurance and Financial Institutions Consumer Services Section at (602) 364-2499 or (800) 325-2548, or you may call WMI at (801) 263-8000 or (800) 748-5340.

Make sure to attach everything that shows why you think WMI should cover your claim or pre-certify a service, including: [ ] medical records, and [ ] supporting documentation (letter from the provider, brochures, notes, receipts). Also attach the certification from your treating provider if you are seeking expedited review.

_____ _____
Signature of insured or authorized representative Date

WMI Mutual Insurance Company ("WMI")
P.O. Box 572450, Salt Lake City, Utah 84157-2450
Telephone: 801-263-8000 Toll Free: 800-748-5340
Claims Fax: 801-263-1189

PROVIDER CERTIFICATION FORM FOR EXPEDITED MEDICAL REVIEWS

(You and your provider may use this form when requesting an expedited appeal.)

A patient who is denied authorization for a covered service is entitled to an expedited appeal if the treating provider certifies and provides supporting documentation that the time period for the standard appeal process (about 60 days) "is likely to cause a significant negative change in the [patient's] medical condition at issue."

PROVIDER INFORMATION
Treating Physician/Provider _____
Phone # _____ FAX # _____
Address _____ City _____ State _____ Zip Code _____

PATIENT INFORMATION
Patient's Name _____ Member ID # _____
Phone # _____
Address _____ City _____ State _____ Zip Code _____

INSURER INFORMATION
Insurer Name _____
Phone # _____ FAX # _____
Address _____ City _____ State _____ Zip Code _____

- Is the appeal for a service that the patient has already received? Yes ☐ No ☐
  If "Yes," the patient must pursue the standard appeals process and cannot use the expedited appeals process. If "No," continue with this form.
- What service denial is the patient appealing? _____
  _____
- Explain why you believe the patient needs the requested service and why the time for the standard appeal process will harm the patient. _____
  _____
  _____

Attach additional sheets if needed, and include: Medical records ☐ Supporting documentation ☐

If you have questions about the appeals process or need help regarding this certification, you may call the Department of Insurance and Financial Institutions Consumer Services Section at (602) 364-2499 or (800) 325-2548, or you may call WMI at (801) 263-8000 or (800) 748-5340.

I certify, as the patient's treating provider, that delaying the patient's care for the time period needed for the informal reconsideration and formal appeal processes (about 30 days) is likely to cause a significant negative change in the patient's medical condition at issue.

Provider's Signature _____ Date _____