DELTA DENTAL OF MISSOURI

MEMBER APPEAL PROCESS

Member requests for appeal must be submitted to DDMO in writing.

Member appeals received via U.S. Mail in the DDMO Data Processing Center (DPC) are stamped with the date received, scanned, and sent in a batch file to the Appeals Team via email at: AppealsDDMO@deltadentalmo.com.

Member's email requests for appeal are considered received on the date sent by the member.

The Appeals Team within the DDMO Customer Service Department is responsible for logging, tracking, managing, and responding to all member appeals in an appropriate and timely manner.

The Appeals Team will review and consider the following, as applicable, for a member appeal:

- The Summary Plan Description (SPD),
- Claim(s) filed, including supporting documentation such as x-rays, narratives, etc.
- Explanation of Benefits (EOBs),
- System notes, call logs, etc.
- Recorded phone calls with member/provider
- Dental consultant review(s)

When clinical review of a member appeal is needed, the appeal is sent to a team of licensed dentists. The team includes five (5) dentists who are independent contractors to DDMO. There are two (2) additional dentists on staff at DDMO, including our Chief Dental Officer.

For plans with a two-level appeal process, decisions on first-level post-service dental appeals will be made within a reasonable period to of time, but in no event later than thirty (30) calendar days from the date of receipt of the request for review.

If the prior benefit determination is overturned, or partially overturned, the claim will be submitted for reprocessing.

The Appeals Coordinator will draft a written response to the member reflecting the benefit determination. If the prior benefit determination was only partially overturned, the appeal response will include the member's right to a second level appeal, as applicable.

If the prior adverse benefit determination is upheld, the Appeals Coordinator will draft a written response to the member reflecting this determination and providing information about the member's right to a second level appeal, as applicable.

The written notice of the decision on appeal will identify the claim by date of service, services provided, and provider. The written notice will include all elements required to be included in such notice of adverse benefit determination by the plan documents, for example: 1) the specific reason or reasons for the adverse determination; 2) references to specific plan provisions on which determination is based; 3) reference to internal rules, guidelines, protocols or similar criteria relied upon in making the determination; 4) member's right to bring a civil action under section 502(a) of ERISA; 5) and other elements as required.