

Michigan Conference of Teamsters Welfare Fund

Messenger



VOLUME 20, ISSUE 5

FALL 2002

Message from the Fund's Executive Director, Richard Burker

In the Summer Issue of the *Messenger* we provided you with a brief introduction to the HIPAA (Health Insurance Portability and Administrative Accountability Act of 1996) Privacy Rules, the first comprehensive federal standards for medical privacy, which will affect virtually every doctor, patient, hospital, drug store and health insurer in America. We are devoting this issue primarily to communication of the Privacy Rules. Also addressed at length are the Fund's Revised Claim and Appeal Procedures in accordance with the Department of Labor's Final Claims Regulation.

The Privacy Rules, which are pursuant to Regulations issued by the U.S. Department of Health and Human Services and become effective April 14, 2003, are designed to provide you with guaranteed protection and security of your health care information – information that your doctor, hospital, pharmacist and other health care provider might have regarding your medical condition and treatments you receive from them.

The Privacy Rules will also affect how the Fund operates on your behalf as well. As your health care plan, we will have to change some of the ways we use your health care information, provide information to you, and work with others that in the past may have had a need for this information.

A New Term to Remember – “Protected Health Information”

HIPAA provides for limitations on the use and disclosure of any information about you which relates to your past, present or future physical or mental health or health care services from which you can be identified. In most cases, such information, when created or received by a health care provider (like your doctor) or a health plan (like the Fund) or a health care clearing house, is deemed “**protected health information**” or “PHI”. This term, beginning in April of 2003, will be applied to any health care information that identifies you and the services you receive from your health care providers. It includes not just information like diagnosis and treatment data, claim detail, and payment information, but also personal information such as your name, address, birth date, sex, or any of a host of other information that could be used to identify you.

In the past this information has been used by the Fund to pay your claims and make certain your records are accurate and up to date. This will not change. However, the Fund must take steps to make sure this information remains confidential and secure. The Fund has always held your information in the strictest of confidence and will continue to do so.

How HIPAA Protections Affect You

You will see appropriate changes coming next spring as we comply with the Privacy Rules. As your health plan, we will not be able to share your “PHI” with others unless you authorize that release of information. So, for example, your spouse or child cannot get information about your health care – whether it is claim information or claim status - without your written permission. Your union representative will not be able to get this information either unless the Fund receives a written authorization from you. These authorizations must be very specific and cannot grant someone “blanket” authority to have access to your information. There are some exceptions to this strict protection, such as if the Fund is served with a court ordered subpoena to release your information.

The Fund's Member Services staff will also have to take extra steps to make sure of your identity when you contact us, whether it is in writing, over the phone, or even when you visit the Fund office.

In addition, the new law provides you with new rights of access to your “PHI” that is kept not only by the Fund, but your doctor, hospital and other providers as well. You will see more steps taken by your doctor, for example, to keep your information confidential as HIPAA applies to all health care providers and health care plans. Your doctor will require you to sign an “authorization” form before he or she will release your records to anyone except in certain cases - such as to file a claim with the Fund or share information with another doctor helping with your medical care. Even then, you can expect that some health care providers may require you to sign either an authorization or some other indicator that you have been advised of your rights to privacy.

Inside this issue:

Notice of Privacy Practices	2
Revised Claim & Appeal Procedures	4

Continued on Page 2

Confidentiality AND Security

In addition to complying with the new Privacy Rules, the Fund must also take specific precautions to ensure that your information is secure. The Fund office has undergone physical changes to prevent unauthorized access to your "PHI". Our entire staff is being thoroughly trained, with the aid of professional consultants, to ensure your privacy through a multitude of procedural changes, electronic (voice and data) security measures and facility security enhancements.

More Information will be coming...

The Privacy Rules are complex and are not entirely clear. Accordingly, we will be following up with FAQs (frequently asked questions and answers) in the Winter Issue of the *Messenger*, with the goal of thoroughly informing you of all rights and obligations under the Privacy Rules.

We urge you to read carefully the Notice of Privacy Practices which follows this article.

NOTICE OF PRIVACY PRACTICES OF THE MICHIGAN CONFERENCE OF TEAMSTERS WELFARE FUND

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

USE AND DISCLOSURE OF HEALTH INFORMATION

The Michigan Conference of Teamsters Welfare Fund ("the Fund") may use your health information, that is, information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), for purposes of making or obtaining payment for your care and conducting health care operations. The Fund has established a policy to guard against unnecessary disclosure of your health information.

THE FOLLOWING IS A SUMMARY OF THE CIRCUMSTANCES UNDER WHICH AND PURPOSES FOR WHICH YOUR HEALTH INFORMATION MAY BE USED OR DISCLOSED:

To Make or Obtain Payment. The Fund may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, the Fund may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits.

To Conduct Health Care Operations. The Fund may use or disclose health information for its own operations to facilitate the administration of the Fund and as necessary to provide coverage and services to all of the Fund's participants and beneficiaries. Health care operations includes such activities as:

- Quality assessment and improvement activities.
- Activities designed to improve health or reduce health care costs.
- Clinical guideline and protocol development, case management and care coordination.
- Contacting health care providers, participants and beneficiaries with information about treatment alternatives and other related functions.
- Health care professional competence or qualifications review and performance evaluation.
- Accreditation, certification, licensing or credentialing activities.
- Underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits.
- Review and auditing, including compliance reviews, medical reviews, legal services and compliance programs.
- Business planning and development including cost management and planning related analyses and formulary development.
- Business management and general administrative activities of the Fund, including member services and resolution of internal grievances.
- Certain marketing activities.

For example, the Fund may use your health information to conduct case management, quality improvement, disease management, utilization review, and provider credentialing activities or to engage in member service and grievance resolution activities.

For Treatment Alternatives The Fund may use or disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Continued on Page 3

For Distribution of Health Related Benefits and Services The Fund may use or disclose your health information to provide to you information on health related benefits and services that may be of interest to you.

For Disclosure to Plan Sponsor. The Fund may disclose your health information to the plan sponsor, the Trustees of the Michigan Conference of Teamsters Welfare Fund, for plan administration functions.

Where Required or Permitted by Law. The Fund also may use or disclose your health information where required or permitted by law. Federal law, under the Health Insurance Portability and Accountability Act of 1996 generally permits health plans to use or disclose health information for the following purposes: where required by law; for public health activities; to report child or domestic abuse; for governmental oversight activities; pursuant to judicial or administrative proceedings; for certain law enforcement purposes; for a coroner, medical examiner, or funeral director to obtain information about a deceased individual; for organ, eye, or tissue donation purposes; for certain government-approved research activities; to avert a serious threat to an individual's or the public's health or safety; for certain government functions, such as related to military service or national security; or to comply with Workers' Compensation laws.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Other than as stated above, the Fund will not disclose your health information other than with your written authorization. If you authorize the Fund to use or disclose your health information, you may revoke that authorization in writing at any time.

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

You have the following rights regarding your health information that the Fund maintains:

Right to Request Restrictions. You have the right to request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Fund's disclosure of your health information to someone involved in the payment of your care. However, the Fund is not required to agree to your request. If you wish to make a request for restrictions, please contact the Fund's Privacy Officer at (313) 964-2400.

Right to Receive Confidential Communications. You have the right to request that the Fund communicate with you in a certain way if you feel the disclosure of your health information could endanger you. For example, you may ask that the Fund only communicate with you at a certain telephone number or by email. If you wish to receive confidential communications, please make your request in writing and mail to: Privacy Officer, Michigan Conference of Teamsters Welfare Fund, 2700 Trumbull Avenue, Detroit, MI 48216. The Fund will attempt to honor your reasonable requests for confidential communications.

Right to Inspect and Copy Your Health Information. You have the right to inspect and copy your health information. A request to inspect and copy records containing your health information must be made in writing and mailed to: Privacy Officer, Michigan Conference of Teamsters Welfare Fund, 2700 Trumbull Avenue, Detroit, MI 48216. If you request a copy of your health information, the Fund may charge a reasonable fee for copying, assembly and postage, if applicable, associated with your request.

Right to Amend Your Health Information. You have the right to request an amendment to your health information records that you believe are inaccurate or incomplete. The request will be considered as long as the information is maintained by the Fund. A request for an amendment of records must be made in writing and mailed to: Privacy Officer, Michigan Conference of Teamsters Welfare Fund, 2700 Trumbull Avenue, Detroit, MI 48216. The Fund may deny the request if you do not state why you believe your records to be inaccurate or incomplete. The request also may be denied if your health information records were not created by the Fund, if the health information you are requesting to amend is not part of the Fund's records, if the health information you wish to amend includes information you are not permitted to change, or if the Fund determines the records containing your health information are accurate and complete.

Right to an Accounting. You have the right to obtain a list of disclosures of your health information made by the Fund for any reason other than for treatment, payment or health care operations, unless you have authorized the disclosure. The request must be made in writing and mailed to: Privacy Officer, Michigan Conference of Teamsters Welfare Fund, 2700 Trumbull Avenue, Detroit, MI 48216. The request should specify the time period for which you are requesting the information, but may not start earlier than April 14, 2003. The right to an accounting does not extend beyond six (6) years back from the date of your request. The Fund will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost based fee. The Fund will inform you in advance of the fee, if applicable.

Right to a Paper Copy of this Notice. You have a right to obtain and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive this Notice electronically. To obtain a paper copy, please contact the Privacy Officer at (313) 964-2400. You also may obtain a copy of the current version of the Fund's Notice at its Web site, www.mctwvf.org.

DUTIES OF THE FUND

The Fund is required by law to maintain the privacy of your health information as set forth in this Notice and to provide to you this Notice of its duties and privacy practices. The Fund is required to abide by the terms of this Notice, which may be amended from time to time. The Fund reserves the right to change the terms of this Notice by providing you with a copy of a revised Notice within sixty (60) days of the change and by making the new Notice provisions effective for all health information that it maintains. If the Fund changes its policies and procedures, the Fund will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change. You have the right to express complaints to the Fund and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Fund should be made in writing and mailed to: Privacy Officer, Michigan Conference of Teamsters Welfare Fund, 2700 Trumbull Avenue, Detroit, MI 48216. The Fund encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

TO CONTACT THE FUND WITH QUESTIONS

Please submit your written questions regarding your privacy rights to: Correspondence Department, Michigan Conference of Teamsters Welfare Fund, 2700 Trumbull Avenue, Detroit, MI 48216, or direct your calls to the Fund's Member Services Department at (313) 964-2400.

EFFECTIVE DATE

This Notice is effective April 14, 2003.

Revised Claim & Appeal Procedures

This is to notify you of material modifications which the Fund has made to its claim and appeal procedures pursuant to the Department of Labor's final regulation governing claims procedures for employee benefit plans, as detailed below. In compliance with the regulation, these modifications have been in effect since January 1, 2002 for disability claims and will go into effect on January 1, 2003 for all group health claims.

INITIAL BENEFIT CLAIM DECISIONS

Post-Service Claims: A post-service claim is a claim for services that already have been rendered or a claim that does not require pre-authorization. Initial decisions on post-service claims will be sent to you within a reasonable time period but not longer than 30 days from the date the Fund receives your claim.

If the Fund determines that an extension is necessary due to matters beyond its control, the 30-day period may be extended an additional 15 days. Prior to expiration of the initial 30-day period, you will be notified of the extension, the circumstances requiring the extension and the date by which the Fund expects to decide the claim.

If the extension is necessary to request additional information from you, the extension notice will describe the required information, and you will have 45 days to submit the additional information. The Fund must make its determination within 15 days after the earlier of the date it receives the requested information from you or your deadline for submitting the information.

Concurrent Care Claims: A concurrent care claim is a claim that arises when there is a reduction or termination of ongoing care. You will be notified if there is to be any reduction or termination in coverage for ongoing care sufficiently in advance of such reduction or termination to permit you to appeal the decision before the coverage is reduced or terminated, unless the reduction or termination is due to a plan amendment or termination of the plan.

Pre-Authorization Claims: A pre-authorization claim is a claim for services that have not yet been rendered and for which the Fund requires prior authorization. If your pre-authorization claim is improperly filed or does not follow the Fund's procedures, you will be notified within five days after the Fund receives the pre-authorization claim.

If your pre-authorization claim is properly filed in accordance with the Fund's procedures, the initial claim decision will be sent to you within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days from the date the Fund receives the claim.

If the Fund determines that an extension is necessary due to matters beyond its control, the 15-day period may be extended an additional 15 days. Prior to expiration of the initial 15-day period, you will be notified of the extension, the circumstances requiring the extension and the date by which the Fund expects to decide the claim.

If the extension is necessary to request additional information from you, the extension notice will describe the required information, and you will have 45 days to submit the additional information. The Fund will make its decision within 15 days after the earlier of the date it receives the requested information from you or your deadline for submitting the information.

Urgent Claims: Some pre-authorization and concurrent care claims may be urgent claims. An urgent claim is any claim for medical care or treatment where making a determination under the normal timeframes could seriously jeopardize your life or health or ability

Continued on Page 5

to regain maximum function, or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that could not adequately be managed without the care or treatment that is the subject of the claim.

If your urgent claim is improperly filed or does not follow the Fund's procedures, you will be notified within 24 hours after the Fund receives the urgent claim.

If your urgent claim is properly filed, a claim decision will be sent as soon as possible taking into account the medical urgency, and in no case later than 72 hours after the Fund receives the claim. You may be notified of the initial decision orally, but a written notice will be provided within 3 days of the oral notice.

You will be notified within 24 hours if your urgent claim is determined to be incomplete and will have 48 hours to provide the additional information.

If you request an extension of urgent care benefits beyond the initially determined period and make the request at least 24 hours prior to the expiration of the original determination, you will be notified of the decision within 24 hours after the Fund receives the request.

Disability Claims: Initial decisions on disability claims (weekly accident and sickness and total and permanent disability) will be sent to you within a reasonable time period, but not longer than 45 days from the date the Fund receives your claim. If the Fund determines that an extension is necessary due to matters beyond its control, this time may be extended for two additional 30-day periods.

The Fund will notify you prior to each extension indicating the circumstances that require the extension, the date by which the Fund expects to make its decision, the standards on which entitlement to a benefit is based, and the unresolved issues that prevent a decision on the claim.

If the extension is necessary to request additional information, the extension notice will describe the required information and you will have 45 days to submit the information. The Fund will make its decision within 30 days after the earlier of the date it receives the requested information from you or your deadline for submitting the information.

NOTICE OF INITIAL BENEFIT CLAIM DECISIONS

You will be notified of the initial decision on your claim. If your claim is filed properly, and your claim is denied in whole or in part, you will receive notice of an adverse benefit determination that will:

- state the specific reason (s) for the adverse benefit determination;
- refer to the specific plan provision (s) on which the determination is based;
- describe additional material or information, if any, needed to perfect the claim and the reasons the material or information is necessary;
- describe the Fund's appeal procedures and the time limits applicable to the appeal procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA following review of an adverse benefit determination;
- disclose any internal rule, guideline, or protocol relied on in making the adverse determination (or state that such information is available free of charge upon request); and
- if the denial is based on a medical necessity or experimental treatment or similar limit, explain the scientific or clinical judgment on which the decision was based (or state that such information will be provided free of charge upon request).

APPEAL OF INITIAL BENEFIT CLAIM DECISIONS

You have 180 days from the receipt of an adverse benefit determination to file an appeal of the decision. Appeals must be sent to the address specified in the adverse benefit determination.

You have the opportunity to submit written comments, documents, or other information in support of an appeal and to have access to all documents that are relevant to your claim. Your appeal will be decided by a person different from the person who made the initial claim decision. No deference will be afforded to the initial decision.

If your claim involves a medical judgment question, the Plan Administrator will consult with an appropriately qualified health care practitioner with training and experience in the field of medicine involved. If a health care professional was consulted for the initial claim decision, a different health care professional will be consulted on the appeal. Upon request, the Plan Administrator will identify any medical expert whose advice was obtained on behalf of the Fund in connection with your appeal.

Post-Service Claims and Disability Claims: If the Fund receives your appeal more than 30 days before the next monthly Trustee meeting, the appeal of your post-service claim will be decided no later than the date of the monthly Trustee meeting that immediately follows the date the Fund received your appeal. If the Fund receives your appeal within 30 days of the next monthly Trustee meeting, the appeal of your claim will be decided no later than the date of the second monthly Trustee meeting following the date the Fund received your appeal.

If special circumstances require a further extension of time for processing your appeal, the appeal of your claim will be decided no later than the third monthly Trustee meeting following the date the Fund received your appeal. In that case, before the extension begins, the Fund will notify you in writing of the need for an extension and describe the special circumstances and the date the appeal decision will be made.

Continued on back page

We're on the Web!!
www.mctwf.org

PRESORT FIRST-CLASS
U.S. POSTAGE
PAID
ROYAL OAK, MICH
PERMIT NO. 686

**MICHIGAN CONFERENCE OF
TEAMSTERS WELFARE FUND**

**2700 TRUMBULL AVE.
DETROIT, MICHIGAN 48216
313-964-2400**

*Metro Detroit 1-800-572-7687
Upstate 1-800-824-3158
Out-of-State 1-800-334-9738*



MICHIGAN CONFERENCE OF TEAMSTERS WELFARE FUND

Labor Trustees
WILLIAM A. BERNARD
H. R. HILLARD
ROBERT F. RAYES

Management Trustees
ROBERT J. LAWLOR
HOWARD McDOUGALL
RAYMOND J. BURATTO

A notice of the appeal decision will be sent to you as soon as possible, but no later than five days after the decision is made.

Concurrent Care Claims: An appeal of an initial decision to reduce or terminate concurrent care that has not yet been provided will be decided as an appeal of a pre-authorization claim. An appeal of an initial decision to reduce or terminate concurrent care that already has been provided will be decided as an appeal of a post-service claim.

Pre-Authorization Claims: You will be notified of the decision on appeal of a pre-authorization claim within a reasonable period of time taking into account the medical circumstances, but no later than 30 days from the date the Fund receives the appeal.

Urgent Claims: You may request an expedited appeal of an urgent claim. The request may be made orally, and the Fund will communicate with you by telephone, facsimile, or similarly rapid communication method. You will be notified of the decision on appeal of an urgent claim as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Fund receives the appeal.

NOTICE OF APPEAL DECISIONS

You will receive notice of the decision on your appeal. If your appeal is denied, the notice of adverse benefit decision will:

- state specific reason (s) for the adverse determination;
- refer to specific plan provision (s) on which the benefit determination is based;
- state that the you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;
- disclose any internal rule, guidelines, or protocol relied on in making the adverse determination (or state that such information will be provided free of charge upon request);
- if the denial is based on a medical necessity or experimental treatment or similar limit, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request); and
- include a statement regarding your right to bring an action under section 502(a) of ERISA.

LIMITATION ON LEGAL ACTIONS

You may not bring a legal action to recover benefits under the Fund until you have exhausted the administrative claim and appeal process described above. You have two years to bring a legal action following the final appeal decision on a claim for benefits issued on or after April 1, 1999. The two-year limitations period applies in any forum where you may initiate an action concerning your claim for benefits. For final appeal decisions issued before April 1, 1999, the Michigan state law limitations period applicable to contracts applies to legal actions concerning claims for benefits.