

---

# **The Denial Is In the Mail**

**Utilizing Consumer Protection Laws  
at Resolving Incorrect Insurance Denials**

**Published by The Center for  
Denied Health Insurance Claims**

Copyright protection claimed includes all letters and materials within. Reproduction of this material is expressly prohibited except as needed for internal purposes. Any subsequent distribution of copies, whether for profit or not, is considered to be copyright infringement.

Disclaimer: This publication provides general coverage of its subject area. It is sold with the understanding that The Center for Denied Health Insurance Claims is not engaged in rendering legal, accounting, or other professional advice or services. If legal advice or other expert assistance is required, the services of a competent professional should be sought. The publisher shall not be responsible for any damages resulting from any error, inaccuracy, or omission contained in this product.

Information in this manual is subject to change without notice and does not represent a commitment on the part of the vendor or The Center for Denied Health Insurance Claims.

[www.integsoft.com/claimdenials](http://www.integsoft.com/claimdenials)

**All Rights Reserved.  
Printed in U.S.A.**

# Contents

- The Denial Is In The Mail 6**
  - Understand Your Health Coverage .....6
  - Understanding Insurance Law Protection .....7
  - Understanding and Utilizing Disclosure Laws .....8
  - Legal Highlight .....12
  
- Section 1: Usual & Customary Denials 15**
  - The Appeal.....15
  - DOL Advisory Opinion.....17
  - Sample Letter .....19
  
- Section 2: Preexisting Conditions 20**
  - The Appeal.....20
  - Sample Letter .....22
  
- Section 3: Medical Necessity 23**
  - The Appeal.....23
  - Legal Highlight .....26
  - Sample Letter .....29
  
- Section 4: Treatment Exclusion/Limitation 30**
  - The Appeal.....30
  - Legal Highlight .....31
  - Sample Letter .....33
  
- Section 5: Maximum Benefits Reached 34**
  - The Appeal.....34
  - Sample Letter .....35
  
- Section 6: Alternative/Complementary Medicine 36**
  - The Appeal.....37
  
- Section 7: Appealing Lack of Precertification/Referral 38**
  - The Appeal.....38
  - Sample Letter .....40
  
- Section 8: Appealing for an Answer to Your Appeal 41**
  - Sample Letter .....42

<b>Pursuing Legal Action</b>	<b>47</b>
<b>Appendix A: State External Review Programs</b>	<b>49</b>

# The Denial Is In The Mail

---

## Understand Your Health Coverage

Health insurance is not cheap. We expect it to come through for us in the event of injury or sickness. We expect that when our doctor files a claim with our health insurance company, it will not be long before the check is in the mail.

Most people are not prepared to hear from the insurance company or the doctor that a claim denial is in the mail. One thing is certain, however, our expectations about how claims will be handled are no longer important. Our response, however, can be extremely important.

As with your health, prevention is the best step to protecting yourself from the frustration of not knowing what to expect from your health insurance company. A health insurance policy is a significant investment for most people and you should fully understand the terms and limitations of that investment. The proliferation of managed care has made the insurance contract exceedingly more complicated. Most people wait until they need the coverage before trying to understand it. However, such timing inevitably leads to frustration and misunderstanding because, when medical treatment is needed, decisions often must be made quickly and the focus is not on following carefully spelled out guidelines but on health. It is far better to sit down at the kitchen table on a rainy day prior to seeking medical treatment and tackle at least the following basic features of your coverage:

- What are the preauthorization and referral requirements for treatment?
- How are out-of-network claims handled?
- How are emergency claims paid?
- What limitations and exclusions are specifically listed under this section?
- How is preexisting condition defined and does it appear to apply to any family member?
- What are the policy maximums and are they different for medical versus mental health treatment?
- What are the time frames indicated for payment of claims and for filing of appeals?

Once the basics are mastered, it is also a good idea to stay in frequent communication with your insurer and medical provider's billing staff as a scheduled treatment approaches. In the days before an upcoming treatment, call both the provider and the insurance carrier to make sure that any referrals or preauthorization are in order. If

you have a managed care policy that requires participants to seek treatment from preferred providers, this is a good time to review your provider's network status and make sure you understand what your liability will be for the treatment.

One more step is becoming increasingly important to protecting the investment you have made in an insurance contract – understanding the insurance laws which apply to your insurance contract. While this can be the most daunting aspect of understanding your rights as a consumer, it is the most critical in terms of conducting a successful appeal of your claim in the event of a denial. This book provides general information about the legal framework which supports your rights to understand every component of your coverage and to appeal denials in such a way that you are assured that claims are handled fairly and denial appeals are given full consideration.

---

## Understanding Insurance Law Protection

The insurance industry is one of the most regulated industries in our nation. There are volumes of federal and state laws which have been enacted primarily to protect you, the consumer.

One of the most basic consumer protections these laws focus on is to protect the consumer for ambiguous contract terms. These laws recognize the need for the insurance contract to have limitations and guidelines, but many insurance laws require that limitations and payment guidelines be (1) disclosed at the time the insurance becomes effective and (2) be clearly worded so that no misunderstanding of the terms and conditions will arise and (3) remain unchanged unless proper disclosure of changes are made to you. Another important consumer protection feature is mandatory insurance coverage statutes. The disclosure requirements and mandatory coverage laws which might apply to your policy differ largely on how you obtained your insurance. Generally, insurance is obtained through the following means:

### Employer-Sponsored Coverage –

Employer-sponsored health coverage is a health insurance plan obtained through your or another family member's place of employment. This type of coverage is governed by federal law, called the Employee Retirement Income Security Act (ERISA). Many people are confused by the reference to Retirement in this acronym. However, the federal laws established to govern any employer-sponsored benefit program, from health coverage to retirement benefits, falls under this body of law.

The federal government began actively regulating insurance in response to the very fact that insurance benefits were increasingly related to a person's employment. One of the challenges ERISA addressed was that large companies operating in several states had to provide separate policies to comply with each state's insurance laws. One of the more significant aspects of ERISA is the federal act allowed employers to be exempt from certain state laws which govern insurance contracts. This gave

employers vast leeway to dictate the specific terms of the contracts. For many years, ERISA plans operated under very loose claims and grievance processing requirements. However, recent federal regulation effective January 1, 2003, was enacted to provide additional protection to consumers regarding the processing of claims for benefits and appeals of disputed claims.

Individually purchased coverage –

Insurance purchased by the consumer directly from the insurance company is governed by state law. Many states have gone well beyond the federal guidelines in seeking to protect the consumer from unfair insurance processing and denials. The majority of the states requires insurance companies to have an internal process for reviewing disputes as well as an external process to have disputes reviewed by an impartial review agent. A section in the back of the book provides state-by-state information about filing an external grievance.

---

## Understanding and Utilizing Disclosure Laws

One of the most frequent complaints of insurance policy holders is that they do not feel their denials were clearly explained or well supported by facts. If this is the case, the insurance consumer must be able to effectively cite their right to disclosure of the claim file information in their requests for additional information and in their appeals. Disclosure laws also fall under state and federal law. As follows are brief citations that you may want to use when making a request for information about your policy. These cites can be used prior to treatment if you are seeking clarification of specific aspects of your policy or during an appeal if you do not believe the insurance company is properly disclosing contract or claim information. Citing legal information in your request may prompt the insurance carrier to respond more fully to your request.

Employer-Sponsored Coverage –

ERISA contains comprehensive disclosure requirements. The Act specifically requires plan administrators — the people who run plans — to give plan participants in writing the most important facts they need to know about their health benefit plans including plan rules, financial information, and documents on the operation and management of the plan. Some of these facts must be provided to participants regularly and automatically by the plan administrator. Others are available upon request, free-of-charge or for copying fees. The request should be made in writing. One of the most important documents participants are entitled to receive automatically when becoming a participant of an ERISA-covered retirement or health benefit plan or a beneficiary receiving benefits under such a plan, is a summary of the plan, called the summary plan description or SPD. The plan administrator is legally

obligated to provide to participants, free of charge, the SPD. The summary plan description is an important document that tells participants what the plan provides and how it operates. It provides information on when an employee can begin to participate in the plan, how service and benefits are calculated, when and in what form benefits are paid, and how to file a claim for benefits. If a plan is changed, participants must be informed, either through a revised summary plan description, or in a separate document, called a summary of material modifications, which also must be given to participants free of charge.

Date

Attn: Director of ERISA Compliance  
Insurance Policy Carrier  
Insurance Policy Address

Re: Name: Policyhold or Patient Name  
Policy: Insurance Policy Number  
Treatment Dates: Admission Date - Discharge Date  
Amount: Total Charges

Dear Director of ERISA Compliance,

This letter is submitted to request additional information regarding the ERISA policy referenced above. As you are likely aware, beneficiaries have extensive rights under ERISA when requesting information about an employee benefit plan. Full disclosure of plan provisions to a beneficiary allows the beneficiary to better understand and follow the requirements of the employee benefit plan. Please accept this formal request for the following information which will assist me in obtaining full benefits under the ERISA plan:

(List any specific items you wish to obtain)

Failure to provide the requested information may affect your ability to assert pertinent policy rights and defenses in a court of law. Further, failure to provide certain information requested by a participant or beneficiary within 30 days after a request can result in a civil penalty of up to \$110 per day. This amount is payable to the participant or beneficiary involved. We look forward to your prompt assistance with this matter.

Sincerely,

## Individually purchased coverage –

State disclosure laws typically govern individually purchased coverage. Most states have laws which require that policy terms be clear and written so that the average person can understand them. Some states have enacted more specific disclosure guidelines.

Almost every state with a few exceptions has passed a ban on gag clauses that prohibit a managed care organization from writing contract provisions that prohibit medical providers from discussing treatment options with patients. However, some states have gone above and beyond this standard and require certain insurers to provide more direct information regarding coverage even prior to or upon appeal of a denial. As follows are a sample of some disclosure laws which might be helpful in your attempt to secure full information about your individually purchased insurance policy:

**California** - Certain insurers must display information in uniform benefits and coverage matrix that includes category descriptions with corresponding copayments and limitations applicable to prescription drug coverage, durable medical equipment, mental health, chemical dependency and home health.

**Florida** – HMOs must provide information concerning the following upon request: the authorization and referral process, determinations of medical necessity, prescription drug benefits, policies and procedures respecting confidentiality and the decision making process regarding experimental treatments.

**Georgia** – Managed Care Organizations must disclose limited utilization incentive plans to enrollees and prospective enrollees upon request.

**Minnesota** – Certain insurers must provide a description of the general nature of the reimbursement methodologies used to pay providers. Further, disclosure of written descriptions of any compensation arrangement that is dependent on the amount of health coverage or health care services provided to the enrollee or the number of referrals to or utilization of specialists and any risk sharing incentive plan must be made. Health plans which cover durable medical equipment must disclose to enrollees, and prospective enrollees upon request, general descriptions of coverage and criteria and procedures for any required prior authorizations and the address and telephone number of a representative to contact for further information.

**Missouri** - HMOs must provide enrollees with specific notice that disputes involving clinical decisions must be made by qualified clinical personnel and further appeal rights, if any. Further, certain emergency services are not subject to prior approval. Finally, specific notice must be given regarding procedures relating to experimental drugs, devices or treatments, and upon written request, written clinical review criteria

relating to conditions or diseases which the organization may consider in the UR process.

**New York** – Certain insurers must provide written disclosure to each insured, and prospective enrollees upon request, regarding the definition of medical necessity in use, UR policies and procedures, grievance procedures, and descriptions of various rights under state law. Additionally items which must be disclosed include information relating to consumer complaints, procedures for protecting confidentiality, a description of procedures for making decisions about experimental status, and (if requested in writing), specific written clinical review criteria relating to a particular condition or disease

**North Carolina** - Information that plans (HMO, PPO) must provide to plan participants and bona fide prospective participants upon request includes, for denials, written reasons and an explanation of the UR criteria relied on, the plan's restrictive formularies or prior approval requirements for obtaining prescription drugs, whether a particular drug or therapeutic class of drugs is excluded from its formulary, and the circumstances under which a nonformulary drug may be covered, and the plan's procedures for determining whether a specified procedure, test, or treatment is experimental; insurers must make the reports filed with the commissioner available on their premises and provided any insured access to them upon request.

N.C. Gen. Stat. § 58-3-191(a) – disclosure (to commissioner) re access/incentives – plan's annual report to the commissioner must include, among other things, (i) the health plan's method for arranging or providing health care services from OON providers, both within and outside of its service area, when IN providers are not available to provider covered services, and (ii) aggregate financial compensation data, including the percentage of providers paid under capitation, discounted FFS or salary, the services included in the capitation payment, and the range of compensation paid by withhold or incentive payments.

**Oregon** - Insurers must furnish to enrollees (or policyholders for distribution to enrollees) written general information including: disclosure of any risk-sharing arrangements with providers; a summary of procedures for protecting the confidentiality of medical records and other enrollee information; notice of information that is available upon request of an enrollee or prospective enrollee, including rules related to the insurer's drug formulary, and a description of risk-sharing arrangement with providers consistent with HCFA requirements; upon request of an enrollee, an insurer must provide a written summary of information that may be considered in UR of a particular condition or disease to the extent the insurer maintains such criteria (but doesn't require an insurer to "advise an enrollee how the insurer would cover or treat that particular enrollee's disease or condition," and proprietary review criteria are subject to verbal disclosure only).

**Pennsylvania** - items for disclosure to each enrollee (and prospective enrollee upon written request) include the following, easily understandable by the layperson: summary of complaint and grievance procedures, including toll-free number and

enrollee's right to designate a representative, notice that emergency services are not subject to prior approval, description of procedures to obtain OON referrals, standing referrals, etc., and a list of information available upon written request (confidentiality protection procedures, process for obtaining non-formulary drugs or drugs for off-label uses, criteria for determinations of experimental status, summary of reimbursement methodologies).

**Texas** - the evidence of coverage is to contain, among other things, notice of the right to go to a OON provider under certain circumstances or request a specialist as PCP.

**Vermont** - plans must disclose the following to each member upon enrollment and annually thereafter (and to prospective members upon request): information about any formulary, the financial inducements offered to any provider for the reduction or limitation of services (does not require disclosure of individual contracts or specific details of any financial arrangement), how members can obtain standing referrals or specialists as PCPs, waiting time and travel standards, opportunities for member participation, consumer information and services available from the state agency, and a list of information available upon request.

**Washington** - upon the request of an enrollee or prospective enrollee, a carrier must provide a written description of any reimbursement or payment arrangements, and information as to whether a plan provider is restricted to prescribing drugs from a plan formulary, what drugs are on the formulary, and the extent to which enrollees will be reimbursed for non-formulary drugs, among other things.

**West Virginia** - all managed care plans (HMOs and prepaid plans) must give subscribers notice of certain rights including: the ability to pursue grievance and hearing procedures without reprisal, the right to privacy and confidentiality, the right to be informed of plan policies and any charges; the ability to obtain evidence of medical credentials of providers, the right to have coverage denials reviewed by appropriate medical professionals.

---

## Legal Highlight

### **Employers Can Be Liable For Stiff Penalties For Failure To Update Employee Benefit Eligibility**

An employee of Hanna Steel terminated his employment with the company in December 1996. It was the responsibility of Hanna Steel to update employee eligibility data in the BCBC of AL computer system. However, Hanna Steel entered

erroneous information in the system and indicated that the employee was still eligible into 1997.

As a result of the inaccurate information in BCBS of AL system, the employee was unable to obtain coverage from his subsequent employer, who also utilized the services of BCBS of AL. In 1997, a family member contracted Hodgkin's disease and received thousand of dollars in medical care. BCBS denied the claims due to the question of eligibility. The former employee sued Hanna Steel for failing to notify him of his right to continue coverage under the Hanna Steel Health Plan.

The District Court of the Northern District of Alabama determined that Hanna Steel did fail to notify the employee and his beneficiaries of their continuation rights. The district court also awarded the family \$93,075.00 in penalties due to Hanna Steel's failure to abide by ERISA's strict disclosure laws. The 11<sup>th</sup> Circuit Court of Appeals upheld the portion of the penalty fee awarded to the beneficiary but reversed the portion of the penalty fee related to the beneficiary's dependents' claims.

**Legal Cite:** United State Court of Appeals for the 11<sup>th</sup> Circuit, No. 01-1037  
Docket No. 99-01748-CV-N-S  
Appeal For US District Court for the Northern District of AL

The 11 sections of this publication each discuss a different denial type in two parts. The first portion, "The Appeal," discusses the how-to's of successfully appealing each type of denial, including pre-treatment groundwork and the actual components of a good appeal letter related to that topic. However, our recommendation on how to successfully appeal claims can be summed up as follows:

**Always place the burden on the payer to prove that its denial is correct and can be supported with written documentation.**

To successfully appeal denials, you must have a conviction that it is the payer's burden of proof to establish that no more benefits are available. Just as insurers now require medical providers to document each step in the patient-provider relationship, so must claim payers document the claim file with all the necessary information to support their decision. We will tell you what types of information to request and how to pursue a payer that is resistant to providing documentation. However, make it your first appeal writing rule to always require insurers and third party administrators to provide the proof to support any denial.

Take note of the suggestions which follow, "Involve Your Provider," in each section. Health care providers are often proactively in regards to appealing denials and can be

a source of assistance in resolving your denial. Often, both the provider and the patient have appeal rights and, if both exercise those rights, the chance for recovery is much greater. Appealing the denial is the most effective way possible is in both your and the provider's interest. Working together is the most effective way to turn the denial into a paid claim and to ensure that insurance carriers fairly review claims.

Insurance carriers require doctors and hospitals to keep extensive medical records to prove that the medical treatment occurred. What proof do you require insurance carriers to provide when they deny your carefully documented claim?

# Usual & Customary Denials

How much is an appendectomy worth?

Insurance companies and medical providers increasingly differ on how much any given procedure should be reimbursed. One of the ways insurance companies protect themselves is through contract limitations stating charges which are above the usual and customary charge for that treatment are not reimbursable. If your provider does not have an agreement to accept the insurer's fee schedule, then the policyholder is typically liable for any balance denied due to U&C limitations. The difference may be several thousand more dollars than you expected to pay for treatment.

The term usual and customary, also called usual, reasonable and customary, should be defined in your policy. However, this definition often does not explain exactly how the reimbursement rates are calculated. Insurance companies often subscribe to an independent service which periodically surveys providers in a given area or they average submitted claims to determine a reasonable charge amount. The size of the sample and the similarities of the facility or providers compared can greatly impact the reimbursement rates. Therefore, it is often helpful to know exactly where the data originated.

Most companies pay claims based upon a percentile of the usual and customary fee schedule. For example, if your policy pays at the 80<sup>th</sup> percentile of usual and customary, that means they pay based upon the fee charged by 80% of the providers for that particular service within the geographical area. Although usual and customary provisions are explained within the policy, policy holders often find it difficult to determine before a scheduled treatment how much they may be liable for.

---

## The Appeal

### Laying the Groundwork

1. Prior to treatment, read the U&C limitation carefully in the policy and, if necessary, contact your insurance carrier to find out if the U&C is applicable to the care you plan to undergo. If so, ask the doctor what specific procedure codes he plans to utilize in the billing and the charge amounts typically submitted for those codes. Submit a written request to the insurance carrier asking for a quote of how much will be paid for these charges. This will allow you to determine if treatment should be sought in network or from a less expensive medical provider. Although the insurance carrier may not provide the requested information, their

failure to advise you prior to treatment of the anticipated reimbursement can be decisive in any legal action which might ensue. Further, failure to provide the information may be a violation of the disclosure laws discussed in the opening chapter.

2. Ask the medical provider how U&C balances are handled. You may want to continue with the treatment if the balance can be billed over time.
3. Ask the insurance carriers where they obtain their reimbursement data and how often this information is updated. As indicated above, failure to provide the information may be a violation of the disclosure laws discussed in the opening chapter.
4. Ask the insurance carrier if the treatment you have planned can be obtained in network. If not, ask if the insurance carrier will pay the claim at a network level of benefits because of its unavailability in your area. Ask your physician for confirmation or an explanation as how similar in-network care compares with the care provided by his or her office.

## Writing a Benefit Reduction Appeal

1. If a quote was requested prior to treatment but not provided, take the position that proper disclosure. Cite ERISA or state disclosure laws, whichever is applicable. If you are unable to obtain a copy of the applicable disclosure law, write a letter which makes the argument that this information should have been provided in fairness to you so that you could make a decision prior to treatment with consideration of your financial liability.
2. Involve Your Provider: Ask your physician how their office determines billing rates. Many medical offices purchase a fee survey for their area that reflects U&C rates. If so, ask for a copy to include with your appeal that establishes that the physician is billing at a fair rate for the area.
3. Demand Documentation: Every appeal letter should request payment of the claim. Every appeal letter should also state that if the denial is upheld, certain documentation should be presented to you to substantiate the denial. On an incorrect payment, ask the carrier to supply a copy of the fee schedule or other data used to determine the payment level. Many insurers balk at providing hard copies of the data used to determine the payment levels. However, most state and federal disclosure laws support your right to review the actual data used to determine payment levels. As follows is a Department of Labor Advisory Opinion interpreting whether ERISA requires plan administrators to provide evidence of the basis for usual and customary charges. This letter states that ERISA does require plan administrators to provide, upon written request, certain documents that specifies procedures, formulas, methodologies, or schedules to be applied in determining or calculating a participant's or beneficiary's benefits. This would be a good enclosure to include with any appeal of usual and customary reductions taken on a claim filed with an employee benefits plan.

## U.S. Department of Labor Advisory Opinion 96-14A

July 31, 1996

Frederick W. Dennerline III, Esq.  
Fillenwarth, Dennerline, Groth & Towe  
1213 N. Arlington Avenue, Suite 204  
Indianapolis, Indiana 46219

96-14A  
ERISA SEC.  
104(b)

Dear Mr. Dennerline:

This is in response to your request for an advisory opinion concerning the scope of section 104(b)(2) and 104(b)(4) of the Employee Retirement Income Security Act of 1974 (ERISA). Specifically, you have inquired whether the schedule of "usual and customary" fees, which is used as a basis for determining the dollar amount that will be paid for health claims made under a welfare benefit plan, must be made available for examination and/or furnished by the plan administrator upon the request of a plan participant or beneficiary.

You represent the Oil, Chemical and Atomic Workers Local Union No. 7-159, whose members are employed by the Kokomo Gas & Fuel Company (the Company). The Company maintains the Kokomo Gas & Fuel Company Health Plan (the Plan). The Plan is a welfare benefit plan and, in many instances, provides for the reimbursement of the full cost of medical care incurred by the employee-participants, based on a "usual and customary" fee.

The Plan document, however, does not include the schedule of "usual and customary" fees. In response to questions concerning the basis for the "usual and customary" charge allowed for certain procedures, participants and beneficiaries have been advised that the information from which the determination of the "usual and customary" fee is derived is proprietary and not disclosable to them. You represent that several participants in the Plan believe that, in order for them to be fully cognizant of their benefit entitlement, they are entitled to disclosure of all of the "usual and customary" recitations set forth in any document which the plan administrator may use to calculate the payment of benefits.

Section 104(b)(2) of ERISA requires that the administrator shall make copies of the plan description, the latest annual report, bargaining agreement, trust agreement, contract, or other instruments under which the plan is established or operated available for examination by any plan participant or beneficiary. Section 104(b)(4) requires the furnishing of such documents to participants and beneficiaries upon written request, although plan administrators may impose a reasonable charge to cover the cost of providing these documents.<sup>1</sup>

## **DOL Advisory Continued...**

The legislative history of ERISA suggests that plan participants and beneficiaries should have access to documents that directly affect their benefit entitlements under an employee benefit plan.<sup>2</sup> Consistent with this Congressional intent, it is the view of the Department of Labor that, for purposes of section 104(b)(2) and 104(b)(4), any document or instrument that specifies procedures, formulas, methodologies, or schedules to be applied in determining or calculating a participant's or beneficiary's benefit entitlement under an employee benefit plan would constitute an instrument under which the plan is established or operated, regardless of whether such information is contained in a document designated as the "plan document." Accordingly, studies, schedules or similar documents that contain information and data, such as information and data relating to standard charges for specific medical or surgical procedures, that, in turn, serve as the basis for determining or calculating a participant's or beneficiary's benefit entitlements under an employee benefit plan would constitute "instruments under which the plan is . . . operated." Thus, it appears that the schedule of "usual and customary" fees described in your letter would be required to be disclosed to participants and beneficiaries in accordance with section 104(b)(2) and 104(b)(4) of ERISA.

This letter constitutes an advisory opinion under [ERISA Procedure 76-1](#). Accordingly, this letter is issued subject to the provisions of that procedure, including section 10 thereof, relating to the effect of advisory opinions.

Sincerely,  
JOHN J. CANARY  
Chief, Division of Reporting and Disclosure  
Office of Regulations and Interpretations

<sup>1</sup> Pursuant to 29 C.F.R. § 2520.104b-30, the charge assessed by the plan administrator to cover the costs of furnishing documents is reasonable if it is equal to the actual cost per page for the least expensive means of acceptable reproduction, but in no event may such charge exceed 25 cents per page. No other charge for furnishing documents, such as handling or postage charges, is considered reasonable.

<sup>2</sup> See H.R. Rep. No. 533, 93d Cong. 1st Sess. 10-11 (1973), and S. Rep. No. 127, 93d Cong., 1st Sess. 27-28 (1973).

---

## Sample Benefit Reduction Appeal Letter

Date

Attn: Director of Claims  
Insurance Policy Carrier  
Insurance Policy Address

Re:     Claim Number:  
       Patient: Patient Name  
       Policy: Insurance Policy Number  
       Insured: Responsible Party Name  
       Treatment Dates: Admission Date - Discharge Date  
       Amount: Total Charges

Dear Director of Claims,

Please accept this appeal of the above referenced claim. According to the explanation of benefits, benefits were significantly reduced due to your determination that the billed charges are more than the usual and customary rate for certain procedures or items.

It is my understanding that usual and customary treatment charges are usually amounts your office considers normally paid on claims for treatment of this nature and within the geographical region where treatment was provided. As you are likely aware, many state and federal disclosure laws require insurers and administrators to advise beneficiaries as to how the reimbursement rate is determined. However, the payment rendered does not appear to be comparable to rates charged for this service locally and no information has been given to support your position that the denial is correct.

Based on this information, please accept this request that the reductions be reversed and an additional payment be made. If your company does not release additional benefits, please submit the applicable policy language which justifies the reduction as well as the data used to establish the reimbursement rate for my review. This will allow me to determine if the data was up-to-date and comprehensive enough to support the denial.

Thank you for your prompt attention to this matter.

Sincerely,

# Preexisting Conditions

Preexisting condition limitation are included in most health insurance policies. Most preexisting limitation have two components. First, the exclusions may limit the amount of time a carrier can exclude coverage for a condition that existed or was treated prior to the effective date. Second, the provision may limit how far in the past the insurance company can investigate the insured's medical history for a preexisting condition. This is often referred to as the look-back period.

One of the more significant differences in the way preexisting is defined is whether the preexisting definition refers to a condition which "existed" prior to the effective date or whether preexisting is defined as a condition which was "treated or diagnosed" prior to the effective date.

With many illnesses, establishing the date of the onset of the illness can be problematic. The patient may have had symptoms of the illness but did not receive a diagnosis until after the insurance became effective. Also, the patient may have received treatment prior to the effective date for an unknown illness. These details should be reviewed for any potential appeal based on medical facts. If your policy defines preexisting as a condition which was treated prior to the effective date, be sure and check your medical records carefully to determine the accuracy of this statement. The letter which follows may be submitted to the carrier to obtain the exact medical records they have obtained to support the denial.

---

## The Appeal

### Laying the Groundwork

1. Read the preexisting definition carefully to determine how this term is defined and what the limitations are.
2. Certain State and HIPAA laws apply to how insurers define pre-existing. If you anticipate undergoing treatment which might be scrutinized for preexisting, contact your state department of insurance to discuss if there are any protections which might apply to how preexisting is defined. Also, if you had coverage previous to the current coverage, contact the insurance carrier to provide details regarding your previous coverage. Some policies have a "No loss-no gain requirement" that means that if you recently switched coverage under which the condition was covered, then the current policies must also cover the condition.

## Appeal Options

1. Request specific information about what proof the insurance company has secured to support the denial. Ask for the name of the doctor and the date on which the diagnosis was made which establishes the treatment as preexisting.
2. Determine if treatment was diagnosed prior to the effective date and if the diagnosis prior to the effective date matches the one currently being treated. If the treatment prior to the effective date was for an unknown condition, make sure to appeal the denial on this basis. There are many court decisions in the patient's favor against a carrier's efforts to apply the preexisting exclusion when the patient merely had symptoms prior to the effective date and not a firm diagnosis.
3. Demand documentation. Ask for written description of the records obtained by the carrier to prove that the condition existed prior to the effective date.

---

## Sample Preexisting Condition Appeal Letter

Date

Attn: Director of Claims  
Insurance Policy Carrier  
Insurance Policy Address

Re: Claim Number  
Patient:  
Policy Number:  
Insured:  
Treatment Dates:  
Amount:

Dear Director of Claims,

It appears that the above referenced claim was denied as a preexisting condition.

The explanation of benefits did not give adequate information to establish the accuracy of this decision. Therefore, please provide the following information to support the denial of benefits for this treatment.

Please furnish the specific medical records in your claim file which supports that this condition was treated prior to the effective date and the specific date on which treatment occurred. Also, please provide a copy of the pre-existing exclusion as it reads in the master policy or plan description.

Further, please provide any information from your files as to whether previous insurance coverage would affect the application of the pre-existing limitation.

Thank you for your assistance.

Sincerely,

# Medical Necessity

Medical necessity denials come in two types – pretreatment denials and post treatment denials. One is a potential threat to your health and the other a threat to your financial health. Medical necessity is perhaps the one type of denial where a well written, well supported appeal can be most persuasive.

Medical necessity reviews are often the areas where the different goals of the medical provider and the insurance company. Practicing medicine is about healing and easing pain but it is also about minimizing liability. Therefore, insurance companies see some treatments and tests as merely undertaken to protect the medical provider from litigation. Insurance is still about profitability. Neither side is anxious to sacrifice its goals to the other. Many medical providers also see a medical necessity denial as very damaging to the patient-provider relationship. Therefore, they are often crucial in their role not only as medical provider but as medical advocate acting in the interest of the patient.

---

## The Appeal

### Laying the Groundwork – Pretreatment Appeals

1. Review the timeframes which apply to making a decision and hold the insurance carrier to the time frames. Your policy may indicate the time frames which apply to pretreatment requests. However, both ERISA and state law may have applicable deadlines for the insurers to abide by. If your coverage is employer-sponsored, information is available at the Department of Labor website, <http://www.dol.gov/dol/pwba/>, regarding ERISA regulations on pretreatment appeals. If your coverage was obtained directly from the carrier, contact your state department of insurance for potential regulations regarding pretreatment appeals. More than half the states have time limits for pretreatment medical necessity decision-making in health plans. Some states set different time limits for urgent and non-urgent cases, while other states do not make any distinctions between type of case. Limits for non-urgent cases range from 2 to 45 days; limits for urgent cases range from 24 to 72 hours.
2. Review the medical necessity definition in the policy and the guidelines and timeframes for appealing medical necessity decisions. Medical necessity is defined by the carrier. Only 11 states have enacted a standard definition which must be used in medical necessity decision. Those states are Connecticut, Hawaii, Illinois, Maine, Minnesota, Montana, Nevada, New Mexico, North Carolina and Vermont. If you are located in one of those states, contact your state's department

of insurance for a copy of the definition so that you can make sure that your insurance carrier does not employ a more restrictive definition.

3. Check to see if your insurance carrier is a member of the Utilization Review Accreditation Commission (URAC) at [www.uran.org](http://www.uran.org) or by calling 212-216-9010. URAC, also known as the American Accreditation HealthCare Commission, is a non-profit charitable organization founded in 1990 to establish standards for the health care industry. Their utilization review accreditation process is designed to ensure that managed care organizations have addressed the issue of quality in both their structure and operations. According to their web site, regulators in almost two-thirds of the states rely on URAC accreditation in some form and their standard for utilization offers the highest level of protection for the consumer. If your insurance carrier is a member of URAC, violations of their standards can be reported and complaints can be filed directly with the accreditation group.
4. Involve Your Provider: If you are concerned that medical necessity may be raised as an issue, ask your treatment provider if you can conference in when they call to precertify the treatment. This will allow you to understand the issues both sides – provider and insurer are concerned with.
5. Demand Documentation – Request a written decision to pretreatment appeal which includes a complete description of the medical opinions the reviewer secured to support its denial. Also, demand a copy of the definition of medical necessity as it appears in the policy or employee benefit plan description. If you proceed with treatment and decide to pursue litigation, a pre-treatment denial outlining the carrier’s position can be very helpful to an attorney who might be reviewing your case.

## **Post-treatment Appeal Options**

1. Involve Your Provider: When appealing treatment which has already occurred, you assume the task of educating the insurance company’s medical staff regarding the efficacy of the treatment already undertaken. Many people who do not have a medical background are justifiably hesitant to try to educate medical professional hired by the insurance carrier. However, you are the one suffering from a specific medical condition and you should not hesitate to use your first hand knowledge regarding your condition and the options for treatment. However, do not limit yourself to just explaining the course of your illness and the need for the proposed treatment. Arm yourself with specific medical information supporting the treatment course in question. The most critical document to submit with your appeal is a letter of medical necessity from your doctors. If possible, submit letters from both your treating doctor and your referring doctor.
2. The more medical information you can submit to support the treatment, the better. Medical reviewers, particularly if you have managed to get the medical director to review the appeal, are looking not only for one doctor’s opinion regarding the best

treatment course but also will find peer-reviewed medical literature such as articles which might appear in academic medical journals compelling. Your doctor is an excellent resource for obtaining peer-reviewed literature to support the treatment. Support groups, patient advocacy groups and the specialty-specific medical internet sites may also be very helpful. See legal highlight below for one law firm's efforts to amass medical literature in support of their lawsuit regarding denied treatment.

3. Take care to outline in your appeal letter factors that may be overlooked in a brief review of the medical information submitted by the provider, such as less invasive measures already taken and whether they were effective, drug interactions, home environment and medical complications unique to you. Ask your physician if medical guidelines, such as Milliman & Roberts Care Guidelines, can be submitted to support the decisions involved. Milliman & Roberts Care Guidelines compile best practices drawn from medical literature, practice observation and expert medical opinions and can be purchased for different treatment settings.
4. Request a review by a medical professional with the same training as the one who will be providing treatment. Check for state licensing of the reviewer. Review for compliance with legal and contractual utilization review requirements. Some laws require an adverse determination to be made by a medical provider licensed in the state. Why is this important? The more medical personnel you can get to review the appeal, the more your odds are of finding someone that will approve the treatment.
5. If you believe certain medical records were ignored, argue that they have insufficient medical records to prove the case. Often the failure of a previous treatment course is a key component in the treating physician's decision to pursue a more aggressive treatment. Make sure the reviewers are aware and have secured the medical records for the previous treatment so they have a complete picture of the history of your medical condition.
6. Seek an independent review of the denial. A majority of the states now have a system for seeking an independent review of a medical necessity denial. A summary of those laws appears in the back of this publication.
7. Demand Documentation – Request a complete description of the medical opinions the reviewer secured to support its position so that you may review the information for applicability to the patient's unique medical condition. Also, demand a copy of the definition of medical necessity as it appears in the policy or employee benefit plan description.

---

## Legal Highlight

### **Carriers Expect Results, but the Medical Necessity Definition May Not Require Them**

Cost containment has lead insurers to increasingly ask for not only a treatment plan but a treatment plan with a good conclusion. However, providers who treat patients with progressive illnesses often are unable to assure case management of a healthy outcome.

In the early 1990's, a multiple sclerosis sufferer began a course of physical therapy and home health care which would ultimately be denied by her insurance carrier, Prudential. Prudential denied about \$47,000 in claims under a general exclusion of unnecessary services or supplies. The company's medical director who reviewed the case stated that the claim denial was correct partly because "physical therapy does not affect the course of MS."

The medical team treating the patient argued that the physical therapy had helped arrest the disease progression. The patient's attorney also successfully argued that improvement was not a criterion under the plan document in question. The plan document defined medical necessity as a service or supply which was (a) ordered by a doctor; (b) recognized as safe and effective, is required for the diagnosis or treatment of the particular sickness or injury and is employed appropriately in a manner and setting consistent with generally accepted U.S. medical standards, and (c) is neither educational nor experimental or investigational in nature.

"Part of the problem with the denial is that if you looked at the plan document's definition of medical necessity, it did not have the requirement of significant improvement. They just had an internal office memo referring to that. The court said it does not govern," said Glen Mullins, the Oklahoma City, OK, attorney who represented the patient.

Mr. Mullins indicated that he compiled about 25 peer reviewed medical articles regarding the medical necessity of physical therapy for multiple sclerosis patients. He also stated that the treating physician's deposition regarding the necessity of care was instrumental in the case. However, Mr. Mullins said the case was unusual in that he was able to get all the documentation he compiled admitted as evidence in the case.

Often, Mr. Mullins said, such lawsuits come down to an administrative law judge reviewing only the records on file at the time the lawsuit is filed. That often includes the medical records as obtained by the insurance carrier but often does not include a description narrative where a more detailed justification for treatment is outlined.

“It is impossible to prevail in a lawsuit if you don’t have the evidence on records before the final decision. Sometimes you know what the doctor ordered X but not the reason for X. You need a detailed narrative,” he said.

In this situation, the need for care was well documented by the physician. Further during the deposition, the doctors were able to expand on the medical issues and one analogized the use of physical therapy in the MS setting to treating malignancies with chemotherapy. He observed that many people suffering from certain incurable cancers are routinely given chemotherapy, a treatment which in some instances, makes the patient worse and often has no effect on the progress of the disease at all. No one, he offered, would characterize chemotherapy as not medically necessary.

Although the medical necessity appeal may be ultimately unsuccessful, Mullins encourages medical providers to consider the potential long-term benefits to filing an appeal with a detailed letter of medical necessity. Even if the appeal is unsuccessful, submitting an appeal will ensure that, if the case goes to trial, the court will have this additional piece of medical information to consider. Mullins also recommends attaching a curriculum vitae or resume to letters of medical necessity to establish the provider’s authority on the subject.

Any information reviewed by the insurance carrier during the appeals process typically becomes part of the claim records and will likely be reviewed by the court if a lawsuit ensues. After reviewing the medical literature and Prudential’s claim file, the Oklahoma Supreme Court overturned the lower court ruling in favor of Prudential.

“Our odyssey through this record makes clear Prudential never evaluated Ms. McGraw’s individual case but rubber stamped the “nature of her condition and denied each subsequent claim arising from her MS,” the court finding states.

*Legal Cite: McGraw v. Prudential Insurance Company of America  
U.S. Court of Appeals for the 10<sup>th</sup> Circuit, No. CIV-95-1076-T  
From the U.S. District Court for the Western District of Oklahoma*

### **ERISA Claims Involving Urgent Care**

In January 2002, the Department of Labor enacted new regulations for responding to claims for urgent care. ERISA group health plans must initially decide urgent care claims within 72 hours after receipt of the claim. Further, the treating physician is given the authority to determine what is an "urgent" claim or not and plans must treat as urgent those requests that are so indicated by the treating provider.

Notification of a decision on an ERISA group health claim can be orally. However, a written or electronic notice of the decision must follow the oral notice within three days of the oral notice. The group health plan must also notify an urgent care provider if there is insufficient information for a decision. Notice must be made not later than 24 hours after receipt of the claim and must indicate the specific information needed to review. Providers are allowed a minimum of 48 hours to provide the requested information.

For more complete information about recent changes in ERISA claims processing procedures go to <http://www.dol.gov/dol/pwba/> and click on frequently asked questions.

---

## Sample Pretreatment Appeal Letter Requesting Documentation to Support Denial

Date

Attn: Medical Director  
Insurance Policy Carrier  
Insurance Policy Address

Re: Patient: Patient Name  
Policy: Insurance Policy Number  
Insured: Responsible Party Name  
Proposed Treatment:

Dear Medical Director,

It is our understanding that my request for preauthorization of the above referenced treatment was denied pursuant to your decision that the care was not medically necessary. However, adequate information to establish the accuracy of this decision was not provided. Therefore, please provide the following information to support the denial of preauthorization of this treatment.

Please furnish the name and credentials of the medical professional who reviewed the treatment records. This information is necessary to determine if the medical professional maintains a medical license for this state. Also, please provide an outline of the specific records reviewed and a description of any records that would be necessary in order to approve the treatment.

Further, we would appreciate copies of any expert medical opinions which have been secured by your company in regards to treatment of this nature and its efficacy so that my physician can more fully review the applicability of that information to my unique medical condition.

Lastly, please indicate what alternative course of treatment your company suggests with your detailed, specific medical reasoning which supports this recommendation. Your immediate response is appreciated.

Sincerely,

Patient Accounts Manager

# Treatment Exclusion/Limitation

Treatment exclusions and limitations must be clearly outlined in the insurance policy or employee benefit plan description. The exclusion or limitation must also be unambiguous and many health benefits lawsuits involving plan exclusions and limitations seek to prevail based on the ambiguity of the limiting language or the insurer's or plan administrator's failure to consistently apply the limitation.

---

## The Appeal

### Laying the Groundwork

1. Many state and ERISA laws appear to indicate that limitations and exclusions must be disclosed prior to treatment, if requested by the beneficiary. It is especially important that an inquiry be made to the carrier regarding upcoming treatment which may have an applicable exclusion or limitation. Specifically, ask the insurance carrier to explain the exclusion or limitation in writing to allow you to better understand the benefits available. A carrier's failure to properly disclose the limitation or exclusion may affect its ability to enforce the clause if the benefit denial ends up in court.
2. Ask the carrier if they provide any additional clarification regarding treatment exclusion and limitations. For example, Aetna U.S. Healthcare publishes coverage policy bulletins that may have more complete information than the policy regarding specific procedures. Aetna U.S. Healthcare's Coverage Policy Bulletins (CPBs) are available online at [http://www.aetna.com/cpb/cpb\\_menu.html](http://www.aetna.com/cpb/cpb_menu.html). CPBs are written on selected clinical issues, especially addressing new technologies, new treatment approaches, and procedures. Although, coverage decisions are made on a case-by-case basis by Aetna U.S. Healthcare, the CPB provide examples of the types of procedures which are covered and, most importantly, exceptions to coverage rules which might be beneficial to cite on appeal. For example, CPB 0031 outlines certain exceptions to exclusions for cosmetic surgery. Aetna U.S. Healthcare does not extend coverage for cosmetic surgery. However, the CPB for cosmetic surgery notes that exceptions are made in the case of repair of accidental injury or for the improvement of the functioning of a malformed body part. Further, the CPB lists a number of specific procedures which are always considered cosmetic and other procedures which will be considered for coverage based on medical necessity criteria. Requesting physicians are instructed to submit documentation, including photographs, letters documenting medical necessity and chart records for approval.

## Appeal Options

1. If the denial is based on medical judgment, as with experimental treatment exclusions, find out the medical credentials of the reviewer. Provide information regarding the treating physician's credentials and past success with the treatment in question as well as peer-reviewed medical literature supporting the efficacy of the treatment.
2. If the denial is based on the diagnosis, make sure that the diagnosis fits the description of the exclusion. For example, some policies may strictly exclude or limit mental nervous treatment. However, some diagnoses are of an organic nature and may not fall under the mental nervous limitation. Some policies name the specific diagnoses that fall under the mental/nervous definition. If mental nervous is not defined by the policy or plan description, you may have an argument that the clause is ambiguous and that the diagnosis you are treating is medical in nature. Also, many mental/nervous treatments begin with a medical treatment period, such as detoxification or emergency treatment of injuries sustained in a psychotic episode, and should be covered under the medical benefits.
3. Demand Documentation. Request a copy of the policy or plan exclusion or limitation and look for an ambiguity in the wording. Court cases consistently require insurance policies and plan descriptions to clearly and in plan language explain any exclusions or limitations to coverage. The courts recognize that the policy or plan language is written by the insurance company or employer and terms are not negotiable. Therefore, any ambiguity or contradictory language is interpreted to the policyholder's benefit.

---

## Legal Highlight

### **Medical Necessity Wording May Take Precedence Over Policy Exclusions**

In October, 1997, the patient in this case began suffering neck, back and headache pain. Her primary care physician recommended bilateral breast reduction. Prior to treatment, she requested a precertification. Precertification was denied based on the fact that the procedure was not a covered benefit based on the following exclusion:

Exclusions or Limitations: We will not pay for:...(q) cosmetic or reconstructive surgery (or any treatment resulting therefrom) ... and (tt) breast augmentation or reduction not associated with cancer of the breast.

However, the policy also stated medically necessary services are covered. A medically necessary service or supply was defined as one which is ordered or authorized by the Primary Care Physician, and which the Primary Care Physician, our medical staff or our Medical Director and/or a qualified party or entity selected by us determines is: provided for the diagnosis or direct treatment of an injury or sickness; (b) appropriate and consistent with the symptoms and findings or diagnosis and treatment of the member's injury or sickness; (c) provided in accord with generally accepted medical practice on a national basis; and (d) the most appropriate supply or level of service which can be provided on a cost-effective basis (including but not limited to, inpatient vs. outpatient care, electric vs. manual wheelchair, surgical vs. medical or other types of care). The fact that the member's physician prescribes services or supplies does not automatically mean such services or supplies are medically necessary and covered by the contract.

In reviewing the matter, the insurance carrier submitted information that one to two cases per week were denied by their precertification department due to the exclusion referenced in this denial. However, the insurance carrier also testified that three requests for breast augmentation had been granted in situations which did not involve cancerous patients. Therefore, the court found that the carrier went beyond a simple cancer review before denying benefits and found that medical necessity was the most likely consideration when such requests were reviewed.

The insurer was not able to establish how many of the past denials were "medically necessary" and how many were simply for cosmetic surgery unrelated to cancer. Because they were not able to demonstrate that the limitation was consistently applied against patients who sought medically necessary treatment for non-cancerous diagnoses, the court found in the favor of the patient and awarded medical benefits.

**Legal Cite:** *Milone vs Exclusive Healthcare, Inc.*

United States Court of Appeals for the 8<sup>th</sup> Circuit, No. 00-1445/1934

Appeal From US District Court for the District of NE

---

## Sample Treatment Exclusion/Limitation Appeal Letter

Date

Attn: Director of Claims  
Insurance Policy Carrier  
Insurance Policy Address

Re: Claim Number:  
Patient:  
Policy Number:  
Insured:  
Treatment Dates:  
Amount:

Dear Director of Claims,

The above referenced claim for health benefits was denied pursuant to a treatment exclusion or limitation in the policy.

The explanation of benefits did not give adequate information to establish the accuracy of this decision. Therefore, please provide the following information to support the denial of benefits for the claim referenced above.

Please furnish a copy of the exclusion or limitation as it reads in the master policy. Also, please provide a copy of any definitions related to the exclusion/limitation as specified in the master policy or other internal claim processing guidelines. I would also appreciate a description of any documentation gathered by your company to substantiate that my illness or injury meets the policy definition and the credentials of the person who made this decision.

Thank you for your prompt clarification of this denial.

Sincerely,

# Maximum Benefits Reached

Health insurance policies typically have limits on the benefits available. There are many different types of policy maximums, including yearly maximums verses lifetime maximums and dollar amounts versus number of days coverage.

The most frequent use of policy maximums is limitations on the benefits related to mental health treatment. However, mental health limitations increasingly fall under some type of state or federal legislation which you should be familiar with if appealing a mental health denial. These laws are called parity laws. Parity laws often require insurers to provide the same level of benefits for mental illnesses or biologically-based illnesses as those available for other physical disorders. Some laws specifically include drug and alcohol treatment under parity requirements and others exclude it. The laws also sometimes specify minimum coverage requirements which might be applicable to not only your yearly and lifetime benefits but also to copayments and deductibles. The National Alliance for the Mentally Ill has a comprehensive state-by-state chart of mental parity laws. Go to <http://www.nami.org/policy/stateparitychart.html> to review the details of your state's requirements.

---

## The Appeal

### Laying the Groundwork

If possible, call prior to treatment and verify that benefits are available and have not been exhausted by previous claims.

### Appeal Options

1. Many states have passed mandatory coverage laws which require a minimal level of benefits be provided for specific conditions. The most frequent example is mental parity laws which require insurers to offer the same level of benefits for mental illness as is available for physical illness. Know your mandatory coverage laws so you can cite these laws in your appeals.
2. Demand documentation - Ask that the claim history be audited for accuracy and that you be provided with the specific treatment providers to whom benefits were paid. This information should also reference the dates and diagnoses related to the

exhausted benefits. If the maximum benefits allow a prescribed number of dates of treatment, you want to ensure that the carrier is not counting each different provider rather than the number of days. Also, you want to confirm that treatment was related to the diagnosis in question.

---

## Sample Maximum Benefits Exhausted Appeal Letter

Date

Attn: Director of Claims  
Insurance Policy Carrier  
Insurance Policy Address

Re:     Claim Number  
          Patient:  
          Policy Number:  
          Insured:  
          Treatment Dates:  
          Amount:

Dear Director of Claims,

It is our understanding that the above referenced claim was denied due to the fact that the maximum benefits were reached for this illness.

(Insert specifics of your confirmation of coverage) According to information provided prior to treatment, your plan provides 30 days of treatment for inpatient treatment for this diagnosis. The plan also allows 30 visits for outpatient services.

Treatment was scheduled based on this assurance of coverage. Therefore, we request immediate payment.

If benefits are denied, please provide the names, dates and amounts paid to previous medical providers for treatment of this and related illnesses so that we may confirm that plan benefits have been exhausted.

Thank you for your prompt attention to this request.

Sincerely,

# Alternative/Complementary Medicine

Alternative/complementary medicine involves alternative medicine interventions that are supported by adequate evidence of safety and effectiveness in the peer reviewed published medical literature that are now utilized and often reimbursed for certain conditions. However reimbursement varies greatly from plan to plan.

The National Institute of Health's Office of Alternative Medicine classifies alternative therapies into the following seven categories:

- Diet and nutrition - use of specific foods, vitamins, and minerals to prevent illness and to treat disease
- Alternative systems of medical practice - use of medicine from another culture (e.g., Ayurvedia, Chinese medicine)
- Herbal medicine - use of plants as medicine
- Mind-body interventions - use of the mind to enhance health (e.g., hypnosis, meditation, yoga)
- Manual healing methods - use of the hands to promote healing (e.g., massage, chiropractic and osteopathic manipulation)
- Pharmacologic and biologic treatments - use of various substances (e.g., drugs, serums) to treat specific medical problems
- Bioelectromagnetic therapies - use of electrical currents or magnetic fields to promote healing (e.g., bone repair, electroacupuncture)

Because the medical community is not in agreement on the efficacy of various alternative medicine, insurers often seek to limit coverage. However, some insurers will cover medically necessary and effective alternative medicine interventions for properly selected patients. Some alternative medicine interventions that are typically excluded from coverage or with limited coverage may be available to members through their participating alternative provider network. However, selection may be very limited. If your insurer is making alternative treatment available but not conveniently available you may have grounds for appeal based on this issue.

Most frequently, however, you will need to focus your appeal on the efficacy of the alternative treatment. It is also important to establish the treatment providers licensing or certification. State laws also vary in regards to requirements for reimbursement of alternative providers.

---

# The Appeal

## Laying the Groundwork

1. Always seek preapproval for any treatment from a complementary/alternative provider. Be sure and note the requirements for ongoing treatment as they may be handled differently from the initial assessment.

## Appeal Options

1. If the services represent the most cost effective approach to the medical service without sacrificing quality of care, be sure to mention this in your appeal letter. Contact your State Department of Insurance to determine if there are state laws mandating coverage for the services you obtained. The most frequently mandated alternative/complementary treatment is chiropractic benefits. About 12 states currently mandate some level of chiropractic coverage. The American Chiropractic Association has a list of those states at [www.amerchiro.org/insurance/policy/states\\_mandate.shtml](http://www.amerchiro.org/insurance/policy/states_mandate.shtml). This site also features a very good letter to a self-insured employer making the case for the cost efficiency of chiropractic care at [http://www.amerchiro.org/insurance/managed\\_care/walmart.shtml](http://www.amerchiro.org/insurance/managed_care/walmart.shtml).
2. Involve Your Provider – Ask the provider’s assistance in getting your treatment approved for payment. Your provider is not only likely familiar with appealing these denials, he or she may also have information specific to your insurer regarding getting the treatment approved for payment.
3. Demand documentation - Ask the carrier to clarify what exclusion or limitation specifically applies to the denial of care. Consult your policy to see if there is any ambiguity in the coverage terms.

# Appealing Lack of Precertification/Referral

Modern healthcare revolves around the managed care permission slip. However, the effect of failing to follow your managed care requirements for precertification or referral can be more serious than being stopped by the hall monitor without a pass. The effect can be financially damaging and a source of undue stress.

This section addresses appeals related to failures to request precertification or referral. This is different from an adverse determination on a precertification or referral request, which most often involves the application of medical necessity or policy exclusions. However, if the medical treatment is a covered service but is not being paid because you did not follow the technical requirements of the managed care contract, the appeal revolves around your timely submission of medical information to secure retroactive approval.

Prompt response to lack of precertification/referral denials is critical. Many policies allow for retroactive review of medical care but have strict guidelines that may apply to requesting retroactive review.

---

## The Appeal

### Laying the Groundwork

1. Contact the insurance carrier by phone as soon as possible to request specific information about securing retroactive approval. Obtain copies of your medical records to submit with the retroactive approval request. Call your provider and schedule a time to pick up your medical records instead of relying on the mail. If they indicate any delay in providing your records, indicate that the medical records are needed immediately by your insurance carrier and any delay in securing the records could damage your ability to obtain payment.

### Appeal Options

1. Know your state's managed care regulations regarding retroactive review of prior authorization. Such laws protect you from certain types of retroactive denials.

2. Involve Your Provider. If the care involves emergency or urgent treatment, ask your provider to provide a brief letter confirming this information.
3. Demand Documentation. Ask for a written confirmation from the insurer that not only was a retroactive review conducted but that the decision was made based on only the information available at the time of treatment. Further, if the appeal involves emergency care, ask if the carrier follows the prudent layperson standard. This term is used in reference to a prudent layperson's knowledge of what constitutes an emergency medical condition and is frequently defined as treatment that a layperson, possessing average knowledge of health and medicine, could reasonably expect the absence of would result in 1) placing the health of the individual in serious jeopardy, 2) serious impairment to bodily functions or 3) serious dysfunction of any bodily organ or part. Also request copies of the exclusion/limitation applicable to the denial to review for applicability.

---

## Sample Request for Retroactive Review Letter

Date

Attn: Director of Claims  
Insurance Policy Carrier  
Insurance Policy Address

Re: Claim Number  
Patient:  
Policy Number:  
Insured:  
Treatment Dates:  
Provider Name(s):  
Claim Amounts:

Dear Director of Claims,

This letter is to request retroactive approval for the medical treatment referenced above. Enclosed are complete medical records to facilitate your review of this medical treatment.

Please be advised, prior authorization was not obtained due to:

(indicate circumstance surrounding the treatment. Be sure to specifically address the following:

1. Whether you felt treatment was required on an urgent or emergency basis
2. Whether you thought approval was obtained by another party
3. Whether a request was made for prior authorization but appears to have been made to the wrong party or through the wrong channels
4. If there was confusion of coordination of benefits and what policy might be primarily responsible

We request your response within any applicable regulatory time constraints for retroactive review. Further, please include with your response the reviewer's credentials, the specific decision with supporting information from the policy and what additional records might be necessary for approval.

Please do not hesitate to call me if you have any questions or need additional information.

Sincerely,

# Appealing For an Answer to Your Appeal

---

## What Do I Do When I Demand Denial Documentation and Don't Get It?

You have a legitimate right to complete and compelling information to support any denial of healthcare. We encourage you to pursue appeals in such a way that, even if the appeal is initially unsuccessful, it results in a more complete explanation from the insurance carrier.

After all, this is about your financial stability.

As discussed in the beginning of the book, state and federal disclosure laws protect your rights to know why a claim is denied. Many of the laws are very specific as to the information which must be contained in a denial letter. As follows is a letter citing the ERISA law which supports the right to obtain denial information from an employer-sponsored plan. If you believe your policy falls under state jurisdiction, rather than federal law, we have also provided a summary of potentially applicable state appeal/grievance response laws which might assist you in obtaining a complete response to your appeal.

---

## Sample Request for Requesting ERISA Appeal Response

Date

Attn: Director of ERISA Compliance  
Insurance Policy Carrier  
Insurance Policy Address

Re:    Patient:  
      Policy:  
      Insured:  
      Treatment Dates:  
      Provider Name(s):  
      Claim Amounts:

Dear Director of ERISA Compliance,

This letter is to advise you that an appeal was filed on (date) regarding denial of the above referenced treatment. However, no response was received from your company. It is our position that this failure to promptly respond to the issues outlined in our appeal letter may be a violation of applicable consumer disclosure laws. Therefore, we request immediate approval of the claim.

It is my understanding that this denial of benefits is governed by ERISA. Under ERISA Section 503, 29 U.S.C. 1133, a plan which denies any claim for benefits must provide the beneficiary with a written explanation of the denial, framed in language that the beneficiary can understand.

Among the specific requirements, the notice of denial must state:

1. the specific reason for denial,
2. specific reference to pertinent plan provisions on which the denial is based,
3. provide a description of additional information necessary to perfect the claim, and
4. provide information on the review procedure.

Because your failure to promptly respond may affect your liability regarding this claim, we request that benefits be immediately allowed. If benefits are not approved, we ask that an appeal response be immediately mailed which meets the disclosure requirements. Please ensure that any decision to deny care references the credentials of the reviewer who reached the decision so that we may verify that he or she has sufficient training to reach the denial decision.

Sincerely,

Alabama – HMO’s must respond to a formal appeal within the time frames established by Ala. Admin. Code r. 420-5-6-.08. Under this regulation, the insurer must provide three level of grievance review and cannot take more than 45 days to provide a written response to the complaint.
Alaska - AS 21.07.020, "Required contract provisions for group managed care plans," requires certain managed care plans to respond to appeals of adverse utilization review determinations within 3 - 18 days and to certain appeals within 72 hours after receiving the appeal.
Arizona – Insurance companies must respond to a formal appeal within 30 days to 60 days depending on type of appeal.
Arkansas - A.S.A. § 23-99-410, "Grievance Procedures," requires a health care insurer issuing or delivering a managed care plan to establish for those managed care plans a grievance procedure which provides covered persons with a <b>prompt and meaningful review</b> on the issue of denial, in whole or in part, of a health care treatment or service.
California - Certain health care plans must respond in writing to grievances within 30 days pursuant to West's Ann. Cal. Ins. Code § 1368.01.
Colorado - Colorado Code of Regulations § 4-2-17 requires health plans to respond to certain appeals within 20 to 45 business days of receipt of the appeal.
Florida – HMO’s must respond to a formal appeal within the time frames established by Fla. Stat. Ann. § 641.511. Under this law, the insurer must provide an internal grievance process which allows grievance to be filed within one year after the date of the occurrence of the action that initiated the grievance. Further, grievances concerning an adverse determinations must be resolved within 60 days after receipt of the grievance, or within a maximum of 90 days if the grievance involves the collection of information outside the service area.
Georgia - Ga. Code Ann. § 33-20A-5(3) requires managed care plans to arrange for an ongoing quality assurance program for the health care service it provides which includes a grievance procedure which provides the enrollee with a <b>prompt and meaningful hearing</b> on the issue of denial, in whole or in part, of a health care treatment or service or claim.
Idaho - I.C. § 41-3918, "Grievance Procedures" requires every managed care organization to establish a grievance system to resolve grievances initiated by members concerning health care services. The system must provide reasonable procedures for the resolution of grievances, and shall include an appeals process which affords the member the right to a <b>prompt review</b> by a grievance panel before whom the member has the right either to appear or be heard, or both.
Illinois - S.H.A. 215 ILCS 125/4-6, "Complaint handling procedure," requires HMOs to provide reasonable procedures for complaint handling.
Indiana - Indiana Code 27-13-10-7 requires HMO’s to establish an internal grievance process that provides an acknowledgement of the grievance in three days and a response within 20 days for most situations.
Kansas - K.S.A. 40-3228 requires HMOs to establish an internal grievance process that provides a response within 20 working days of filing for most situations.
Maine - Maine requires health plans to establish an internal appeal process that provides a response within 72 hours if the covered person's ability to regain maximum function is at risk or within 20 working days of receipt of the appeal for less urgent situations. Further appeals must be evaluated by appropriate clinical peers who were not involved in the initial determination. Please see Code Me. R. Ch. 850, "Health Plan Accountability," § 8G .
Maryland - Maryland requires health plans to establish an internal grievance process that provides a response within 30 days of filing for most situations. Further, certain emergency-related appeals must

be responded to within 24 hours or 45 days when the services have already been provided.
Massachusetts - Massachusetts Health Insurance Consumer Protection Regulations, 105 CMR 128.305 requires certain carriers to response to appeals of adverse determinations within 30 days.
Minnesota - M.S.A. 62Q.70, "Appeal of the complaint decision," requires insurers to provide an internal appeal process meeting certain requirements, including giving the complainant written notice of the appeal decision and all key findings within 30 days of the health plan company's receipt of the complainant's written notice of appeal. If a complainant appeals by hearing, the health plan company must give the complainant written notice of the appeal decision and all key findings within 45 days of the health plan company's receipt of the complainant's written notice of appeal.
Missouri - Mo. Ann. Stat. § 376.1381 requires a health carrier that offers managed care plans to describe its grievance procedure in member materials. Carrier must conduct investigations within 20 – 30 business days with notice within 15 business days of completion.
Montana - Montana requires health maintenance organizations to establish a complaint system that provides an acknowledgement of a complaint within 10 days of receipt under R.C.M 33-31-303, "Complaint System."
Nebraska - Nebraska requires managed care plans to establish an internal grievance process that provides a response within 15 to 30 working days of filing for most situations. Further, the review time frame must be "as expeditiously as the covered person's medical condition requires." Please see R.R.S. 1996, § 44-7308.
Nevada - Review boards must complete reviews regarding a complaint or appeal and notify the insured of its determination not later than 30 days after the complaint or appeal is filed, unless the insured and the review board have agreed to a longer period of time. If a complaint involves an imminent and serious threat to the health of the insured, the managed care organization shall inform the insured immediately of his right to an expedited review of his complaint. If an expedited review is required, the review board shall notify the insured in writing of its determination within 72 hours after the complaint is filed. See. Nev. Rev. Stat. § 695G.210
New Jersey - N.J. Administrative Code, Title 8 r. 38-3.6 requires HMOs to respond to an appeal within 30 days from receipt of the appeal.
New Mexico – Managed health care plans must provide two levels of internal complaint review and cannot take more than 30 days to provide a written notice of the decision unless there is a delay in obtaining requested documents. The complaint must be responded to within five days from receipt of a complaint for urgent care, out-of-network services or medically necessary care. Second level reviews must be conducted by a committee with not more than half having any previous involvement in the care. See N.M. Admin. Code title 13.10.13.14.
New York – Insurers must acknowledge a grievance within fifteen business days of receipt of the grievance. All grievances shall be resolved in no more than: (1) forty-eight hours after the receipt of all necessary information when a delay would significantly increase the risk to an insured's health; (2) thirty days after the receipt of all necessary information in the case of requests for referrals or determinations concerning whether a requested benefit is covered pursuant to the contract; and (3) forty-five days after the receipt of all necessary information in all other instances. See New York Ins Code § 4408..
Oregon - Or. Rev. Stat. Ann. § 743.804(3) requires insurers to have a “timely and organized” system that includes an appeal process with 2 levels of review, the second of which is by persons not previously involved in the dispute, and written decisions in plain language justifying appeal

[determinations.](#)

Pennsylvania - 40 P.S. § 991.2161 establishes that grievance reviews must be completed within 30 to 45 days of receipt of the grievance. Further, at least two levels of grievance review must be provided and second level reviews must be conducted by a licensed physician or, where appropriate, a licensed psychologist. Expedited time frames apply if the enrollee's life, health, or ability to regain maximum function is in jeopardy.

Rhode Island – The Rhode Island Utilization Review Act states in 23-17.12-9 that patients must be notified in writing of appeal decisions no later than fifteen (15) or twenty-one (21) working days if verbal notice is given within fifteen (15) working days after receiving the required documentation on the appeal. Expedited appeals process for emergency or life threatening situations must be responded to within two (2) business days of the date the appeal is filed and all information necessary to complete the appeal is received by the review agent.

South Dakota - S.D. Admin. R. 20:06:34 states that a grievance concerning any matter may be submitted to a managed care plan or utilization review organization by or on behalf of a covered person within three years of the act giving rise to the grievance. Standard reviews must be answered in writing within thirty calendar days following the request for a review. If a grievance is based on an adverse determination and the timeframe of a standard review would seriously jeopardize the life or health of a covered person or would jeopardize the covered person's ability to regain maximum function, a managed care plan or utilization review organization shall provide for expedited review.

Tennessee - T.C.A., § 56-32-210, "Complaint system," mandates that grievances shall be reviewed by the HMO grievance committee within ten (10) working days of receipt of the grievance and all necessary information; provided this time may be extended by written notice to the covered person that review cannot not be accomplished within ten (10) working days, such extension not to exceed an additional ten (10) working days. The health maintenance organization shall provide to the covered person the name, address and telephone number of a person designated to coordinate the grievance review on behalf of the health maintenance organization upon receipt of the grievance.

Texas - Texas HMOs must acknowledge a complaint orally or in writing of a complaint no later than the fifth business day after the date of the receipt of the complaint and 30 days to investigate and resolve the complaint.

Utah - [Utah Admin. Code R. 590-76](#) requires an HMO medical director or physician designee to review all grievances of a medical nature and answer grievances in writing within 30 days of submittal.

Vermont - Managed care plans must respond to grievances within the time frames established by Vt. Reg. R. 10.203(D). Under this regulation, managed care plans must provide a grievance procedure which responds to grievances related to emergency or urgent care as expeditiously as the condition requires but no more than three days after receipt of necessary information. Non urgent grievances are to be responded to with 15 days for grievances related to medical care and 30 days for grievance related to other issues. A second review must also be available with a response time of two days for urgent cases and 30 days for other grievances.

Virginia - [Va. Admin. Code 14:5-210-70](#) requires grievances to be resolved within reasonable period of time, not more than 180 days from date registered (subject to extension in the event of delay in

obtaining documents or mutual agreement).

Washington - RCW 48.43.055, "Procedures for review and adjudication of complaints," requires health carriers to provide a fair review for consideration of complaints. Health carriers must provide reasonable means whereby any person aggrieved by actions of the health carrier may be heard in person or by their authorized representative on their written request for review. If the health carrier fails to grant or reject such request within thirty days after it is made, the complaining person may proceed as if the complaint had been rejected. A complaint that has been rejected by the health carrier may be submitted to nonbinding mediation. Mediation shall be conducted pursuant to mediation rules similar to those of the American arbitration association, the center for public resources, the judicial arbitration and mediation service, RCW 7.70.100, or any other rules of mediation agreed to by the parties.

# Pursuing Legal Action

---

If your appeals to the insurance company ultimately fail, litigation is typically the only option you have left. Of course, the decision to litigate is often not an easy one and we simply cannot answer the crucial question you might have, “Will I prevail?”

However, the information we have provided is meant to support this option should you decide to consult an attorney. Filing a timely appeal which seeks review and requests supporting documents not only increases the likelihood of payment, it also can assist your attorney if litigation is pursued.

Many insurance contracts specifically require that appeals be exhausted before litigation is initiated. Therefore, appealing denials and obtaining written responses to those appeals may help to satisfy the requirements on your contract. Further, exhausting administrative remedies is statutorily required before pursuing litigation on an ERISA plans. Many policies and health benefits plans require two appeals to be filed prior to legal action. If you file suit without filing the required appeals, the insurance company and plan administrator will often ask the judge to dismiss the case based on this failure to follow dispute resolution steps required in the agreement. Judges strictly enforce such wording in order to keep such matters out of the already clogged legal system.

## **Negotiating with an attorney**

Attorneys can be retained either at an hourly rate or on a contingency basis. A contingent fee is a charge made by an attorney dependent upon the successful outcome in the case and is often agreed to be a percentage of the client’s recovery. Law firms are often more willing to represent you on a contingency basis if, after reviewing the circumstances of the case, they believe the insurer has acted in bad faith and penalties other than the medical expenses can be pursued.

If you retain a law firm at an hourly rate, discuss with your attorney the possibility of filing immediately for summary judgment rather than gathering deposition and seeking a jury trial, both very time consuming factors in litigation. Many attorneys are hesitant to litigate in this manner because of the potential for legal malpractice. However, if the wording of the insurance contract appears to be clear and there is a simple question of the legal interpretation of the contract terms, summary judgment may be your most inexpensive means of getting the case into the courtroom. This may

be especially beneficial if the insurance carrier has not responded to your appeals. Such inaction is likely to be viewed in your favor by a reviewing judge.

Small claims court – Small claims court is an option for resolving smaller claims. Small claims courts are often less formal than other types of courts and more conducive to self-representation. Further, you may still opt to ask an attorney to review your case and provide a short legal brief on the legal arguments which support your case. A flat fee could be negotiated for this service and might better prepare you for presenting the case in small claims court.

During your initial consultation with the attorney, be prepared to make your case convincing. Have a copy of the insurance policy with pertinent clauses marked for quick reference. Bring copies of your appeal letters and the insurance carrier's responses. If the history is detailed and the carrier's lack of timely response is an issue, prepare a timeline that summarizes the dates requests were made to the carrier and when responses were provided and in what form. Be sure to bring to the attorney's attention any information the carrier neglected to provide or if any erroneous information was provided that affected payment of your claim.

# Appendix A: State External Review Programs

---

This appendix provides tables with information about the external appeal processes available in each state. Where pertinent, information about the internal appeal process is also provided. Follow the procedures for your state, which were current as of June 2003. For more information, call the state agency or access the state web site listed at the bottom of each page. If your state does not have an external review program, check with your health plan about its internal appeal requirements or with the Department of Labor about filing an appeal if your plan is a self-insured employer-sponsored plan.

# Alabama

## General Information:

As of August 31, 2002, Alabama did not have an external review program for denials of coverage for services that health plans consider either experimental or not medically necessary. Alabama does provide administrative review through the Department of Public Health.

## How to Get More Information:

Contact your health plan.

Alabama Department of Public Health, 334-206-5300

# Alaska

## General Information:

The Alaska Patient Bill of Rights Law passed in April 2000 and became effective July 1, 2001. Unlike other states, the Alaska Division of Insurance does not have a direct role in the external appeal process.

## The External Appeal Process:

Whom to contact:	Your health plan
Who can appeal:	You or your health plan
What you can appeal:	<ol style="list-style-type: none"><li>1. Denials of coverage for services the health plan determines are not medically necessary or are experimental or investigational, or</li><li>2. Denials of coverage when medical judgment is needed to determine whether or not the service is a covered benefit under the plan, or</li><li>3. Denials of coverage based on failure to meet your health plan's internal appeal deadlines.</li></ol>
When you can appeal:	You must make a "timely appeal" in writing.
What to send:	<p>You are allowed to submit evidence related to the issues in dispute. The law requires the External Appeal Agency to consider:</p> <ol style="list-style-type: none"><li>1. The standards and guidelines used to make the decision,</li><li>2. Pertinent personal health or medical information,</li><li>3. Your provider's opinion,</li><li>4. The group health insurance plan.</li></ol> <p>The external appeal agency may also consider:</p> <ol style="list-style-type: none"><li>1. Reliable and valid studies,</li><li>2. Government conducted or financed professional conference results,</li><li>3. Government treatment and practice guidelines,</li><li>4. Government coverage and treatment policies,</li><li>5. Generally accepted principals of medical practice,</li><li>6. Expert opinions,</li><li>7. Peer reviews,</li><li>8. Community standard of care,</li><li>9. Anomalous utilization patterns.</li></ol>
What you must pay:	Charges incurred by you or your physician in support of the external appeal.
What will happen:	The External Appeal Agency will make a decision and supply the decision in writing to you and your health plan as soon as possible.
When you will get a decision:	No later than 21 working days after the appeal is filed.
In urgent situations:	An expedited review will be completed within 72 hours after the request for an external appeal.

## How to Get More Information:

Contact your health plan.

# Arizona

## General Information:

Arizona distinguishes between “denied services” (care you have yet to receive) and “denied claims” (for care you have already received). To appeal either, you must start with an internal appeal. For denied services, you must request an Informal Reconsideration (or, if urgent, an Expedited Medical Review). For denied claims, your insurer may allow you to begin with the Informal Reconsideration or may require you to initiate a Formal Appeal.

If the insurer continues to deny your request, you may file a Formal Appeal with the insurer within 60 days of the completion of the Informal Reconsideration of a denied service or up to two years after a denied claim. The insurer has 30 days to make a decision on denied services and 60 days for denied claims. If the Formal Appeal is denied, you may request an External, Independent Review.

The External, Independent Review Process (reflects legislative amendments effective March 1, 2001):

Whom to contact:	Your health plan
Who can appeal:	You, your provider, or your authorized representative
What you can appeal:	Denied claims or denied requests for services
When you can appeal:	You must appeal within 30 days after receiving notification of denied formal appeal or within 5 days after an expedited appeal denial.
What to send:	Either write a letter or use the request form provided in your health plan’s information packet. You are not required to use the form.
What you must pay:	No charge
What will happen:	<p>The insurer will send a copy of the policy, medical records, all documents used to render the decision, and a description of the issues and the basis for the decision to the state Department of Insurance (DOI).</p> <p>For denials based on a coverage issue:</p> <ol style="list-style-type: none"> <li>1) Within 15 days of receiving the information, the DOI will review and determine if the service or claim is covered under the policy.</li> <li>2) The DOI will mail a notice of the decision to you, your health plan, and your treating provider.</li> <li>3) If the DOI cannot make a decision, it may refer the case to an independent review organization.</li> </ol> <p>For denials based on medical necessity:</p> <ol style="list-style-type: none"> <li>1. Within 5 days of receiving the information, the DOI will send your case to an independent review organization (IRO).</li> <li>2. The independent reviewer will evaluate the case, make a decision within 21 days, and send a notice of the decision to the DOI.</li> <li>3. Within 5 business days of receiving the IRO’s decision, the DOI will send a notice to you, your health plan, and your treating provider.</li> </ol>
When you will get a decision:	For standard reviews based on coverage issues: within 20 business days from the date your request is received. For standard reviews based on medical necessity: approximately 36 days from the date your request is received.
In urgent situations:	To be eligible for the three-tiered expedited appeal process, your treating provider must submit a written certification to your insurer and send supporting documentation indicating that waiting through the standard appeal process is likely to cause a significant negative change in your medical condition at issue. After you have completed 2 internal expedited levels of review, you may request expedited external review, which will be completed within 3 business days (for coverage issues) or 9 business days (for medical necessity issues).

## How to Get More Information:

Statewide: 1-800-325-2548

[www.state.az.us/aid](http://www.state.az.us/aid)

# Arkansas

## General Information:

As of August 31, 2002, Arkansas did not have an external review program for denials of coverage for services that health plans consider either experimental or not medically necessary.

## How to Get More Information:

Contact your health plan.

# California

## General Information:

California's Department of Managed Health Care provides a 24 hour a day, seven day a week HMO Help Center which can resolve the simplest HMO problem as well as the most complicated medical disputes. Those complicated disputes are resolved through the HMO Help Center's independent medical review program, where independent doctors consider HMO and health plan denials around treatments the health plan deems not medically necessary or experimental. The doctors can overturn the HMO's decision, which is binding and enforced by the Department. The Department resolves problems for commercial as well as Medi-Cal HMO's enrollees.

## The Complaint Resolution and Independent Medical Review Process:

Whom to contact:	California Department of Managed Health Care's HMO Help Center
Who can appeal:	You, your provider (with consent), or your authorized representative
What you can appeal:	An HMO's or health plan's decision, including ones regarding experimental or investigational treatment and disputed medical necessity services.
When you can appeal:	If you are unable to resolve your problem with your HMO, you must request review within 6 months of your HMO's or health plan's denial of care or grievance determination.
What to send:	Call the HMO Help Center for more information. Some problems can be resolved immediately, some require medical records, and independent medical review applications can be requested over the phone.
What you must pay:	No charge
What will happen:	The California HMO Help Center will: 1. Determine what the best course of action is for your complaint, including Independent Medical Review. If you qualify for Independent Medical Review, the reviewers will: 2. Notify you and your HMO or health plan that the case has been accepted. 3. Complete the review and make a decision in writing.
When you will get a decision:	Usually within 30 days
In urgent situations:	Call the Department's HMO Help Center for emergency or urgent situations.

## How to Get More Information:

California Department of Managed Health Care, [www.hmohelp.ca.gov](http://www.hmohelp.ca.gov)

California HMO Help Center: 1-888-HMO-2219  
TDD 877-688-8981  
Fax 916-229-4326

# Colorado

## General Information:

Colorado specifies two levels of internal review, but the health plan may choose to skip the first level and handle appeals at the second level. If applicable, the first level appeal must be completed within 20 days of the request (72 hours for an expedited review). At the second level, the health plan's appeal panel must meet within 45 days of the request (for both standard and expedited reviews) and produce a decision within 5 days of the meeting. You have a right to appear in person or by conference call or video conferencing at the panel meeting. If your appeal is denied, your health plan will tell you how to file for an independent external review.

## The Independent External Review Process:

Whom to contact:	Your health plan
Who can appeal:	You, your provider (with consent), or your authorized representative
What you can appeal:	Denials of coverage for services the health plan determines are not medically necessary or are experimental.
When you can appeal:	After denial for coverage has been appealed through all levels of the health plan's internal process, you must appeal within 60 days from receipt of the final adverse determination.
What to send:	A completed request form
What you must pay:	No charge
What will happen:	<ol style="list-style-type: none"><li>1. Health plan notifies the insurance department by fax that you have requested an external review.</li><li>2. The insurance department assigns an independent external reviewer.</li><li>3. The health plan sends all relevant information to the reviewer. The reviewer may request additional information from you, your doctor, or your health plan.</li><li>4. The reviewer makes a decision and notifies you, your health plan, and the department of insurance.</li></ol>
When you will get a decision:	Within 30 working days (the deadline may be extended 10 additional working days if additional information needs to be considered).
In urgent situations:	If a delay will jeopardize your health (you must have your doctor's certification), you can get an expedited review within 7 days. This can be extended 5 more days if the reviewer needs more time.

## How to Get More Information:

Colorado Division of Insurance, 303-894-7490  
[www.dora.state.co.us/insurance](http://www.dora.state.co.us/insurance)

# Connecticut

## General Information:

Connecticut requires you to exhaust all internal appeal procedures at your plan or its utilization review company before you begin the external appeal process.

## The External Appeal Process:

Whom to contact:	Connecticut Insurance Department
Who can appeal:	You, your provider (with consent), or your legal representative
What you can appeal:	Denials of coverage for services covered in your contract that your health plan determines are not medically necessary
When you can appeal:	After denial for coverage has been appealed through <b>all</b> levels of the health plan's internal process, you must appeal within 30 days from receipt of the <b>final denial letter from the health plan.</b>
What to send:	<ul style="list-style-type: none"><li>• A completed "Request for External Appeal" form (available from the Insurance Dept)</li><li>• Evidence of enrollment (such as a photocopy of your insurance card)</li><li>• Copies of all pertinent correspondence</li><li>• Copy of letter saying all internal appeals have been exhausted</li><li>• Copy of certificate of coverage</li><li>• Filing fee</li></ul>
What you must pay:	\$25 (the fee is waived under certain conditions)
What will happen:	<ol style="list-style-type: none"><li>1. The Insurance Department will assign the appeal to an external review agent.</li><li>2. The external review agent will conduct a preliminary review to determine if the request is eligible for full review.</li><li>3. If the request is eligible, the external review agent will notify you, or your provider, and the plan of the opportunity to submit additional information within 5 business days. The external review agent will complete a full review and notify the Insurance Dept. of its decision.</li><li>4. The Insurance Dept. will notify you, your doctor, the plan, and the utilization review company.</li></ol>
When you will get a decision:	Preliminary review: 5 business days after receipt of appeal Full review: 30 business days after completion of the preliminary review
In urgent situations:	No expedited external appeal process

## How to Get More Information:

State of Connecticut Insurance Department, 1-800-203-3447 (in-state only)

[www.state.ct.us/cid](http://www.state.ct.us/cid)

# Delaware

## General Information:

For managed care organizations, Delaware specifies 2 stages of internal review for health plans. Stage 1 must be completed within 5 days, and stage 2 must be completed within 30 days. For conditions that cause an imminent, emergent, or serious threat to the health of the enrollee, each stage may take no more than 72 hours. If immediate medical attention is required, both stages must be concluded within 72 hours. If you receive an adverse determination after the internal reviews, then you can apply for the independent health care appeals program.

All commercial plans (including managed care organizations and excluding ERISA plans) are subject to the Independent Health Care Appeals Process.

## The Independent Health Care Appeals Process:

Whom to contact:	Your health plan
Who can appeal:	You or your authorized representative
What you can appeal:	Denial, reduction, or termination of health care benefits that deprive the covered person of medically necessary covered services.
When you can appeal:	You must file within 60 days after you receive notice of an adverse determination from your health plan.
What to send:	A written request: <ol style="list-style-type: none"><li>1. Your name &amp; address</li><li>2. Your health plan information</li><li>3. A brief request for review by IHCAP (Independent Health Care Appeals Program)</li></ol> <p>There is no limitation on supplying additional information to the IURO.</p>
What you must pay:	No charge
What will happen:	<ol style="list-style-type: none"><li>1. Your health plan will notify the Department of Health and Social Services (DHSS).</li><li>2. DHSS will assign an Independent Utilization Review Organization (IURO).</li><li>3. The IURO will review the case and make its determination as appropriate.</li><li>4. The IURO will make a decision and notify you.</li></ol>
When you will get a decision:	45 days after receipt of a completed application for appeal review
In urgent situations:	If your case involves an imminent, emergent, or serious threat to the health of the enrollee or if immediate medical attention is required, the appeal process will not exceed 72 hours.

## How to Get More Information:

Delaware Office of Health Facilities Licensing and Certification, 1-800-942-7373 or 302-995-8521

# District of Columbia

## General Information:

The District of Columbia sets out 3 separate levels of grievance appeals: informal internal review by the insurer, formal review by the insurer, and formal external review by an independent review organization.

Informal internal appeals are to be completed within 14 business days, and within 24 hours for urgent or emergency care. Formal internal appeals are to be completed within 30 business days, and within 24 hours for urgent or emergency care.

## The Formal External Review Process:

Whom to contact:	Director of the District of Columbia Department of Health
Who can appeal:	You, your provider (with consent), or your authorized representative
What you can appeal:	Denial, reduction, limitation, termination, or other delay of covered health care services.
When you can appeal:	After denial for coverage has been appealed through the health plan's formal internal process, you must file within 30 days from receipt of the written decision of the health plan. If the health plan fails to meet the deadlines for completing a formal internal appeal, the member may begin the external process without waiting for the health plan's decision.
What to send:	<ol style="list-style-type: none"><li>1. Written request for appeal</li><li>2. Completed medical record consent form</li><li>3. Final decision of health plan</li></ol>
What you must pay:	No charge
What will happen:	<p>The Director will:</p> <ol style="list-style-type: none"><li>1. Evaluate the appeal for processing (is the complainant a member, are the requested services covered benefits, is all information available, etc.)</li><li>2. Notify you whether the appeal is eligible for processing</li><li>3. If acceptable, assign the appeal on a rotating basis to an independent review organization.</li></ol> <p>The independent review organization will:</p> <ol style="list-style-type: none"><li>1. Conduct a full review by at least 2 physicians.</li></ol> <p>Either you or a health plan representative may request to appear in person at a hearing by the review organization.</p>
When you will get a decision:	Within 30 business days from the time the independent review organization is assigned.
In urgent situations:	You may be able to start the appeals process before completing the informal and formal urgent appeals in cases of emergency or urgent care. An expedited appeal will be completed within 72 hours from the time the independent review organization is assigned.

## How to Get More Information:

District of Columbia Department of Health, [www.dchealth.dc.gov](http://www.dchealth.dc.gov)  
Grievance and Appeals Coordinator, 202-442-5979

# Florida

## General Information:

Florida requires health plans to address problems through their internal grievance procedure before seeking resolution through the Statewide Provider and Subscriber Assistance Program. By law the internal grievance process should require no more than 60-90 days to complete. After completing the internal process, you are eligible to file a grievance with the Statewide Provider and Subscriber Assistance Program.

## The External Appeal Process:

Who to contact:	Statewide Provider and Subscriber Assistance Program (SPSAP)
Who can appeal:	You, your provider (on your behalf), or your authorized representative
What you can appeal:	Denials of coverage for services the health plan determines are not medically necessary or are experimental or investigational, non-authorization or denial of services you believe are covered by the plan, out of network requests.
When you can appeal:	You must file <u>only</u> after completing all levels of the health plan's internal grievance procedure. You must file within 365 days of receiving the notice of final denial.
What to send:	A completed "Request for Review and Release Form"
What you must pay:	No charge
What will happen:	<ol style="list-style-type: none"> <li>1. You send the release form and supporting information.</li> <li>2. The health plan submits pertinent information.</li> <li>3. The SPSAP analyst determines whether the case is one over which the program has jurisdiction.</li> <li>4. The SPSAP analyst prepares the information for a hearing.</li> <li>5. A hearing is scheduled.</li> <li>6. You and your health plan attend a video-teleconference with the SPSAP panel. You and your health plan will each have 15 minutes to present your case, and 5 minutes of rebuttal, if necessary.</li> <li>7. The SPSAP panel will evaluate the case and prepare a written recommendation within 15 working days, unless more time is needed to gather necessary information requested by the panel.</li> <li>8. You and your health plan have 10 days after receiving the recommendation to submit written objections.</li> <li>9. A final determination will be made by the Agency or the Department of Insurance, depending upon which department has jurisdiction in the case. You will be notified by certified mail.</li> <li>10. The health plan has 30 days to comply if the final order is in your favor.</li> </ol>
When you will get a decision:	Within 165 days
In urgent situations:	An expedited review is available for cases in which there is a serious threat to continued health. An expedited review is scheduled for hearing within 45 days and resolved within 65 days. If there is an impending threat of death, an emergency case is heard within 24 hours.

## How to Get More Information:

For quality of care: Agency for Health Care Administration, 1-888-419-3456  
[www.fdhc.state.fl.us/MCHQ/Consumer/SPSAP/index.shtml](http://www.fdhc.state.fl.us/MCHQ/Consumer/SPSAP/index.shtml)

For billing or enrollment problems: Insurance Consumer Helpline, 1-800-342-2762

# Georgia

## General Information:

Georgia health plans must have internal review processes. If you have exhausted your health plan's internal appeals, you may apply for external review.

## The Independent Review Process:

Whom to contact:	Office of General Counsel, Department of Community Health
Who can appeal:	You or your authorized representative
What you can appeal:	Health plan denials of treatment for services that cost more than \$500 and either appear to be covered services or are experimental treatments for patients with terminal conditions.
When you can appeal:	You must file after you have received a notice of adverse outcome from your health plan.
What to send:	A completed form or written request stating: <ol style="list-style-type: none"><li>1. Name of person seeking treatment</li><li>2. Name of authorized person acting on patient's behalf</li><li>3. Address &amp; phone number of enrollee</li><li>4. Name of health plan and policy number</li><li>5. Copy of the notice denying treatment from the health plan</li></ol>
What you must pay:	No charge
What will happen:	<p>The Office of General Counsel will:</p> <ol style="list-style-type: none"><li>1. Notify you in writing that your request was received.</li><li>2. Determine if you are an eligible enrollee.</li><li>3. Randomly assign your case to an independent review organization and provide you with its name and address.</li></ol> <p>You or the health plan may be required to provide more information or documents within 5 days (although you may request an extension to 10 days).</p> <p>The independent review organization will:</p> <ol style="list-style-type: none"><li>1. Review your case.</li><li>2. Made a determination in writing.</li></ol>
When you will get a decision:	15 days after the "additional information" deadline
In urgent situations:	If the standard time frame would jeopardize your health, life, or ability to regain maximum function, an expedited review may provide a decision with 72 hours after the reviewer receives all requested documents.

## How to Get More Information:

Georgia Department of Community Health, Division of Health Planning, 404-656-0545  
[www.communityhealth.state.ga.us/](http://www.communityhealth.state.ga.us/)

# Hawaii

## General Information:

Hawaii requires health plans to establish internal review procedures that provide a decision within 45 days, or within 72 hours if medical circumstances require an expedited review. The response from the health plan will explain how to apply for external review. You must exhaust the health plan's internal review process prior to filing a request for external review.

## The External Review Process:

Whom to contact:	The Hawaii Insurance Commission – Health Insurance Branch
Who can appeal:	You, your provider (with consent), or your authorized representative
What you can appeal:	Denials of coverage or payment for services the health plan determines are not medically necessary or are experimental or investigational.
When you can appeal:	The written request must be received within 60 days of the date of the health plan's final internal determination.
What to send:	A written request for review
What you must pay:	No charge
What will happen:	<ol style="list-style-type: none"><li>1. Your health plan will send any documents to the reviewer within 7 days of notification (within 48 hours for an expedited review).</li><li>2. The insurance commissioner will appoint a 3-member review panel.</li><li>3. For disputes involving less than \$500, the insurance commissioner may conduct a review without appointing a review panel.</li><li>4. A review hearing will be conducted within 60 days of the original request</li><li>5. The review panel will decide whether your health plan acted reasonably by a majority vote.</li><li>6. The commissioner of insurance will issue an order affirming, modifying, or reversing the health plan's decision within 30 days of the hearing.</li></ol>
When you will get a decision:	Within 90 days of the request for review
In urgent situations:	For an expedited review, the health plan must send documents within 48 hours and the review must be completed within 72 hours.

## How to Get More Information:

Hawaii Department of Commerce and Consumer Affairs, Insurance Division, Health Insurance Branch, 808-586-2790  
[www.state.hi.us/dcca/ins/](http://www.state.hi.us/dcca/ins/)

# Idaho

## General Information:

As of August 31, 2002, Idaho did not have an external review program for denials of coverage for services that health plans consider either experimental or not medically necessary.

## How to Get More Information:

Contact your health plan.

# Illinois

## General Information:

Illinois requires health plans (HMOs) to follow an internal appeal procedure that requests the necessary information within 3 days of receiving the appeal, and to provide a decision within 15 business days after receiving the information. If your medical situation requires an expedited review, the health plan must request the information within 24 hours and provide a decision within 24 hours after receiving the information. If your request is denied, you may request external review from your health plan. You may also file a complaint *at any time* with the Illinois Department of Insurance.

## The External Independent Review Process:

Whom to contact:	Your health plan
Who can appeal:	You, your provider (with consent), or your authorized representative
What you can appeal:	Denials or limitations of coverage for health care services your health plan considers are not medically appropriate.
When you can appeal:	After completing all levels of your health plan's internal appeal procedure, you must file within 30 days of receiving written notice of an adverse determination.
What to send:	A written request, including necessary information or documentation to support your request.
What you must pay:	No charge
What will happen:	<ol style="list-style-type: none"><li>1. Your health plan will provide for selection of an external independent reviewer jointly by you, your provider, and the health plan.</li><li>2. Your health plan will provide all documentation to the reviewer.</li><li>3. The reviewer will make a decision within 5 days of receiving all information.</li></ol>
When you will get a decision:	In general, 35 days after your health plan receives the request for external review.
In urgent situations:	An expedited review is available if denial of the service could significantly increase the risk to your health; a decision will be made within 24 hours of receiving all necessary information.

## How to Get More Information

Illinois Office of Consumer Health Insurance, 877-527-9431  
[www.ins.state.il.us/OCHI/Office\\_Consumer\\_Health\\_Ins.htm](http://www.ins.state.il.us/OCHI/Office_Consumer_Health_Ins.htm)

# Indiana

## General Information:

Health plans' internal appeals must meet regulatory guidelines and be approved by the Department of Insurance annually. After you have completed all levels of the internal process, you may file for external review.

## The External Review Process:

Whom to contact:	Your health plan
Who can appeal:	You, your provider, or your authorized representative
What you can appeal:	Denials or limitations of coverage for services the health plan determines are not appropriate, medically necessary, or are experimental or investigational.
When you can appeal:	After denial for coverage has been appealed through all levels of the health plan's internal process, you must file within 45 days from receipt of the final adverse determination.
What to send:	A written request for external review
What you must pay:	The health plan may charge you up to \$25 towards the cost of the review.
What will happen:	<ol style="list-style-type: none"><li>1. The plan selects an independent review organization for your case on a rotating basis and sends pertinent information.</li><li>2. The reviewer may ask for additional information.</li><li>3. The reviewer will notify you and your health plan of the decision.</li></ol>
When you will get a decision:	Within 15 business days of filing for review
In urgent situations:	If a delay will seriously jeopardize your health, life, or ability to regain maximum function, an expedited review can be completed within 72 hours of filing.

## How to Get More Information:

Indiana Department of Insurance, Consumer Services, 1-800-622-4461 (in-state) or 317-232-2395  
[www.state.in.us/idoi](http://www.state.in.us/idoi)

# Iowa

## General Information:

Iowa has no state requirements for a health plan's internal review procedure.

## The External Review Process:

Whom to contact:	Iowa Insurance Division
Who can appeal:	You or your provider (with consent)
What you can appeal:	Denials for medical service claims your health plan believes are not medically necessary.
When you can appeal:	After denial for coverage has been appealed through all levels of the health plan's internal process, you must file within 60 days of the denial.
What to send:	<ol style="list-style-type: none"><li>1. A letter detailing why you are requesting the review and providing a return address and day-time phone number for both you and your provider.</li><li>2. A photocopy of the letter denying coverage from your health plan.</li><li>3. The \$25 filing fee.</li></ol>
What you must pay:	\$25 (The fee will be refunded if the decision is in your favor, or the fee may be waived by the Commissioner).
What will happen:	The health plan will select an independent review agent from a list approved by the insurance department.
When you will get a decision:	Approximately 35 days for an uncontested review and 45 days for a contested review
In urgent situations:	If a delay would jeopardize your health, an expedited review may be requested and a decision will be delivered within 72 hours

## How to Get More Information:

Iowa Insurance Division, 877-955-1212

[www.iid.state.ia.us](http://www.iid.state.ia.us)

# Kansas

## General Information:

Kansas requires health plans to have and disclose their internal grievance procedures to their members. If your request for services is turned down, you will receive an *adverse determination* letter from your health plan. If a final decision has not been made within 60 days (unless the delay was due to your request), you may file for independent medical review.

## The Independent Medical Review Process:

Whom to contact:	Kansas Insurance Commissioner
Who can appeal:	You, your provider (with consent), or your authorized representative
What you can appeal:	Denials of coverage for services the health plan determines are not medically necessary or are experimental or investigational.
When you can appeal:	After denial for coverage has been appealed through all levels of the health plan's internal process (except for an expedited appeal), you must file within 90 days from the adverse determination.
What to send:	A completed form, which includes a medical records release. You should also write a letter summarizing your situation and providing as much information as possible, including any medical literature that supports your case.
What you must pay:	No charge
What will happen:	<ol style="list-style-type: none"><li>1. The Insurance Commissioner reviews the case within 10 days to determine if it qualifies for review.</li><li>2. If the case is accepted, it is sent to the external review organization.</li><li>3. You and your health plan have 7 days to provide additional information.</li><li>4. The case is assigned to a physician.</li><li>5. The review organization notifies you, your health plan, and the Insurance Commissioner of the decision.</li></ol>
When you will get a decision:	Within 30 business days after submitting your request
In urgent situations:	An expedited review is available for an emergency medical condition; the case is immediately evaluated and sent to the review organization, you have 5 days to provide additional information, and a decision will be made within 7 business days.

## How to Get More Information:

Kansas Insurance Department, 1-800-432-2484 (in state)  
[www.ksinsurance.org](http://www.ksinsurance.org)

# Kentucky

## General Information:

Kentucky categorizes health plan refusals for service as either *coverage denials* or *adverse determinations*. A coverage denial involves services, treatments, drugs, or devices that the health plan claims are not covered by the health plan contract. An adverse determination involves services, treatments, drugs, or devices that the health plan claims are not medically necessary or appropriate, or are experimental or investigational. If you receive either a “notice of coverage denial” or a “denial letter of adverse determination,” you are eligible to ask the health plan for an internal appeal which will be completed within 30 days of the request (or within 3 business days of the request if you are hospitalized or a treating physician states that a review under the standard time frame could jeopardize your health).

If you are not satisfied with the result of appealing a *coverage denial*, you can write the Department of Insurance and request a coverage denial review. If the coverage denial requires resolution of a medical issue, the Department may require your health plan to allow you an external review.

If you are not satisfied with the result of appealing a *denial letter of adverse determination*, you can contact your health plan and request an external review.

## The External Review of Adverse Determination Process:

Whom to contact:	Your health plan
Who can appeal:	You, your provider (with consent and authorization), or your authorized representative
What you can appeal:	Adverse determinations: services, treatments, drugs, or devices that the health plan claims are not medically necessary or appropriate, or are experimental or investigational, for services that would have cost you at least \$100 if you had no insurance.
When you can appeal:	After you exhaust the health plan’s internal appeal process, or if you and your health plan agree to waive the internal appeal process, you must file within 60 days after receipt of an adverse determination.
What to send:	Written request, medical records release, and written designation/authorization of person or provider, if applicable.
What you must pay:	\$25 filing fee payable to the independent review entity (may be refunded if the decision is in your favor, or may be waived for financial hardship).
What will happen:	<ol style="list-style-type: none"><li>1. Your health plan will determine whether or not to grant an external review based upon established criteria and arrange the external review, if indicated.</li><li>2. If you are not granted a review, you may file a written complaint with the Department of Insurance and the Department will decide whether or not you will receive an external review within 5 days.</li><li>3. If you are granted an external review, an independent review entity will be assigned to your case.</li><li>4. The independent review entity decides your case.</li></ol>
When you will get a decision:	Within 21 days (unless you and your health plan agree to an additional 14-day extension)
In urgent situations:	If you are in the hospital or your treating physician states that an external review under the 21-day timeframe could jeopardize your health, a determination will be made in 24 hours (unless you and your health plan agree to an additional 24-hour extension).

## How to Get More Information:

Kentucky Department of Insurance, 1-800-595-6053 or 800-462-2081 (Hearing Impaired)

# Louisiana

## General Information:

Louisiana requires health plans to be authorized as Medical Necessity Review Organizations (MNRO) or to use an approved MNRO to make medical determinations about the appropriateness of care. If your request is denied, your provider may ask for an informal reconsideration of the decision. If you receive an adverse determination, Louisiana provides for both a first level internal appeal and a second level review process. In the second level review process, you have the right to discuss your situation in person. If your second level review upholds the adverse determination, you can request an external review. If a delay will seriously jeopardize your life, health, or ability to regain maximum function, an expedited appeal is available. It is possible that your health plan has an approved internal procedure that allows you to begin the external review process without completing a second level review, or will agree to waive requirements for the internal appeal or review.

## The External Review Process:

Whom to contact:	The Medical Necessity Review Organization (MNRO)
Who can appeal:	You, your provider (with consent), or your authorized representative
What you can appeal:	Denials of coverage for services the health plan determines are not medically necessary.
When you can appeal:	After denial for coverage has been appealed through all the levels of the health plan's internal process, you must file within 60 days from receipt of the second level appeal adverse determination.
What to send:	File a request with the MNRO
What you must pay:	No charge
What will happen:	<ol style="list-style-type: none"><li>1. The MNRO will send all pertinent information to its designated independent review organization within 7 days of the request.</li><li>2. The review organization will evaluate the information and respond with a recommendation to you, the MNRO, and your provider.</li></ol>
When you will get a decision:	Within 30 days after receiving the necessary information, unless everyone involved agrees to a longer period.
In urgent situations:	If you receive an adverse determination involving an emergency medical condition while being treated in an emergency room, during hospital observation, or as a hospital inpatient, your provider may request an expedited review. A decision will be made and you will be notified within 72 hours after the review organization receives the necessary medical information.

## How to Get More Information:

Louisiana Department of Insurance Help Desk, 1-800-259-5300 or 225-219-4770

# Maine

## General Information:

If your health plan gives you an adverse determination on an initial request for services, Maine allows your provider to request an informal reconsideration. If this does not resolve the difference of opinion, Maine provides for two levels of internal appeal. At the first level appeal, a decision is due within 20 working days of the request for review, unless that time frame cannot be reasonably met. For an expedited appeal, a response is due within 72 hours after the review is initiated. If the first level appeal does not resolve the differences, a second level appeal is available. If you are still denied coverage after a second level appeal, you can request an independent external review.

## The Independent External Review Process:

Whom to contact:	Maine Bureau of Insurance, Consumer Health Care Division
Who can appeal:	You, your provider (with consent), or consumer's written authorized representative
What you can appeal:	Denials of coverage for services the health plan determines are not medically necessary, are experimental or investigational, or are based on pre-existing condition exclusions.
When you can appeal:	You must file within 12 months from receipt of the final adverse health care treatment decision. Although you must usually exhaust all levels of the health plan's internal process, this is not required if: 1. The internal grievance is not resolved in the required time period, 2. You and your health plan agree to bypass the internal procedure, 3. Your life or health is in serious jeopardy, or 4. You have died.
What to send:	A written request to the Maine Bureau of Insurance, Consumer Health Care Division
What you must pay:	No charge
What will happen:	1. The Bureau of Insurance sends your request to a contracted independent review organization. 2. You have the right to request a hearing (telephone conference). 3. The health plan has to send all pertinent records to you and the review organization. 4. You may submit additional information to the review organization. (who will send copies of that information to your health plan). 5. The review organization will make a decision and notify you, your health plan, and the Bureau of Insurance.
When you will get a decision:	Within 30 days of the date the case is received by the external review organization
In urgent situations:	If delay will seriously jeopardize your life, health or ability to regain maximum function, the decision must be made within 72 hours of the request for review.

## How to Get More Information:

Maine Bureau of Insurance, 1-800-300-5000 (in Maine)

[www.maineinsurancereg.org](http://www.maineinsurancereg.org)

# Maryland

## General Information:

Maryland requires health plans to establish an internal grievance process that provides a response within 30 working days of filing for most situations, within 24 hours for emergencies, and within 45 working days when the services have already been provided. If you receive an adverse decision, you may file a complaint for review of the grievance decision. You must first, however, exhaust the health plan's internal grievance process.

## The Appeal Process:

Whom to contact:	Maryland Insurance Administration (MIA)
Who can appeal:	You, your provider (with consent), or your health plan
What you can appeal:	Denials of coverage for services the health plan determines are not medically necessary or are experimental or investigational. There is also a separate <u>appeals process for coverage decisions</u> .
When you can appeal:	After denial for medical necessity has been appealed through the health plan's internal process, you must file within 30 working days from receipt of the final adverse determination. If there is a compelling reason as determined by the MIA, you may go directly to the MIA.  After denial of a coverage decision has been appealed through the health plan's internal process, you must file within 60 working days from receipt of the final appeal decision, except for an urgent medical condition.
What to send:	A written appeals and grievances complaint, including copies of all relevant documentation, such as the denial letter from the health plan and pertinent <u>medical records</u> .
What you must pay:	No charge
What will happen:	For a medical necessity appeal: <ol style="list-style-type: none"> <li>1. The MIA will notify your health plan within 5 working days after receiving your request.</li> <li>2. Your health plan will provide all pertinent information within 7 working days of notification.</li> <li>3. The MIA may seek advice from an independent review organization.</li> <li>4. <u>The MIA will investigate your case and return a final decision.</u></li> </ol>
When you will get a decision:	For medical necessity: Within 30 working days of filing a complaint with the MIA if the service has not been provided; within 45 working days if the service has already been provided. The deadline may be extended up to an additional 30 working days if the pertinent information has not been received or it is necessary.  <u>For coverage decisions: The time requirement for investigation may vary.</u>
In urgent situations:	For expedited reviews you will receive a response within 24 hours. If your appeal "involves compelling circumstances" you may skip the health plan's internal process and file directly with the MIA.

## How to Get More Information:

Maryland Insurance Information, 1-800-492-6116 (1-800-735-2258 TTY)  
[www.mdinsurance.state.md.us](http://www.mdinsurance.state.md.us)

For help in filing appeals forms, call the Attorney General Health Education and Advocacy Unit, 877-261-8807  
 Complaint form and medical release forms are available on the web site under Consumer Information.

# Massachusetts

## General Information:

Massachusetts' external review process applies to any fully insured Massachusetts-based health plan. First file an internal grievance through your health plan, which the plan must resolve within 30 business days of receiving all necessary information (or within 5 days for emergency cases) unless you agree to extend the time frame. If the plan does not respond within 30 days the services are automatically covered. If you receive written notice of a final adverse determination from the health plan, you may file for external review.

Included within the Office of Patient Protection is the Office of the Managed Care Ombudsman, which is available to assist health plan members with questions and concerns regarding managed care, grievances, appeals, denials of care, continuity of care, and independent external reviews. Call 1-800-436-7757.

## The External Review Process:

Whom to contact:	Office of Patient Protection, Massachusetts Department of Public Health
Who can appeal:	You, your provider (with consent), or your authorized representative
What you can appeal:	Any denial of a medically necessary service covered by the health plan.
When you can appeal:	You must file within 45 days of receipt of your health plan's final adverse determination letter.
What to send:	Follow the procedures provided by your health plan or request an external review application from the Office of Patient Protection.
What you must pay:	\$25 (may be waived for financial hardship)
What will happen:	The Department of Public Health will randomly assign your case to an external review agency. The review agency will evaluate the case and return a decision.
When you will get a decision:	Usually within 60 business days after the review agency receives the request from the Department of Public Health, although the review agency may request an additional 15 business days. If there is a serious or immediate threat to the patient, a decision must be made within 5 business days.
In urgent situations:	To be eligible for the expedited appeal process, your treating provider must submit a written certification to your insurer and send supporting documentation indicating that waiting through the standard appeal process is likely to cause a substantial risk of serious harm to the patient. After you have completed the internal expedited levels of review, the expedited external review will be completed within 5 business days.

## How to Get More Information:

Office of Patient Protection, 1-800-436-7757 or fax 617-624-5046

[www.state.ma.us/dph/opp/](http://www.state.ma.us/dph/opp/)

# Michigan

## General Information:

Michigan law requires you to complete an internal review with your health plan prior to using the external review. The health plan will give you a final decision within 45 days and will provide an Office of Financial and Insurance Services (OFIS) Health Care Request for external review form. If your health plan does not provide a decision within the required time frame, you may file for External Review without the notice of final adverse determination.

## The External Review Process:

Whom to contact:	Michigan Office of Financial and Insurance Services (OFIS)
Who can appeal:	You or your authorized representative
What you can appeal:	The availability, delivery, or quality of health care services, including a complaint regarding an adverse determination, as well as issues concerning the contract between you and your health plan.
When you can appeal:	After denial for coverage has been appealed through the health plan's internal process, you must file not later than 60 days from receipt of a notice of final adverse determination.
What to send:	<ol style="list-style-type: none"><li>1. Completed OFIS Health Care Request for External Review form.</li><li>2. Copy of the written final adverse determination from your health plan.</li><li>3. Any additional supporting information.</li></ol>
What you must pay:	No charge
What will happen:	<ol style="list-style-type: none"><li>1. OFIS reviews your request and checks that the denied service is covered.</li><li>2. If the grievance involves non-medical issues, it will be reviewed by OFIS staff.</li><li>3. If the grievance involves medical issues, the request is assigned to an Independent Review Organization (IRO).</li><li>4. The Independent Review Organization reviews medical information and the denial and makes a recommendation within 14 calendar days.</li><li>5. OFIS reviews the recommendation of the Independent Review Organization.</li></ol>
When you will get a decision:	The review process takes approximately 26 days to complete: <ol style="list-style-type: none"><li>1. OFIS will review your request within 5 business days.</li><li>2. The IRO has 14 calendar days to evaluate your case and make a recommendation.</li><li>3. In most cases, OFIS will contact you regarding the final decision within 7 business days of receiving the IRO recommendation.</li></ol>
In urgent situations:	If the denial seriously jeopardizes your life, health, or ability to regain maximum function, you may file for an expedited external review at the same time an expedited request is made to the health plan. OFIS will issue a decision within 72 hours. <b>The urgency of the condition must be substantiated in writing by a licensed physician.</b>

## How to Get More Information:

Michigan Office of Financial and Insurance Services (OFIS), 877-999-6442  
[www.michigan.gov/cis/0,1607,7-154-10555\\_12902\\_12907---,00.html](http://www.michigan.gov/cis/0,1607,7-154-10555_12902_12907---,00.html)

# Minnesota

## General Information:

For complaints that do not involve medical determinations, the internal complaint process for Minnesota health plans can take 30 days. If the complaint is not resolved in your favor, you can then appeal to the health plan, with a response in 30 to 45 days. If your complaint involves a medical determination, it will be handled by the 30-45 day appeal process. If an appeal is not resolved in your favor, you may apply for the external review process.

Minnesota's external review process also applies to other health insurers such as Blue Cross/Blue Shield plans and indemnity plans, but the case must be filed with the Minnesota Department of Commerce.

## The External Review Process:

Whom to contact:	Minnesota Department of Health
Who can appeal:	You, your provider (with consent), or your authorized representative
What you can appeal:	Denials of coverage for services the health plan determines are not medically necessary or are experimental or investigational. You can also appeal grievances related to contract disputes or other services.
When you can appeal:	You must file after the dispute has been appealed through the all levels of the health plan's internal process and you have received an adverse determination.
What to send:	<ol style="list-style-type: none"><li>1. A completed Request for External Review, which includes a medical records release.</li><li>2. \$25 check.</li><li>3. Any supporting information for your case.</li></ol>
What you must pay:	\$25 (may be waived in cases of hardship)
What will happen:	<ol style="list-style-type: none"><li>1. The Department of Health will evaluate your case for eligibility.</li><li>2. Your case will be sent to an independent review organization<ol style="list-style-type: none"><li>a. If your case does not involve a medical determination, you may request mediation, which involves a hearing by telephone or in person.</li><li>b. If no agreement is reached, your case will be returned to the review organization.</li></ol></li><li>3. You, your provider, and your health plan will be notified within 3 days after the review organization receives the case.</li><li>4. You, your provider and your health plan may submit pertinent information to the review organization within 10 days after notification.</li><li>5. The review organization will evaluate your case and make a decision.</li></ol>
When you will get a decision:	Within 40 days after the case is submitted to the independent review organization
In urgent situations:	For medical determinations for services that have not been received or are ongoing, if your provider believes an expedited review is necessary, a decision will be made within 72 hours.

## How to Get More Information:

Minnesota Department of Health, 1-800-657-3916  
[www.health.state.mn.us/divs/hpsc/mcs/extrevufaq.htm](http://www.health.state.mn.us/divs/hpsc/mcs/extrevufaq.htm)

# Mississippi

## General Information:

As of August 31, 2002, Mississippi did not have an external review program for denials of coverage for services that health plans consider either experimental or not medically necessary.

## How to Get More Information:

Contact your health plan.

# Missouri

## General Information:

Missouri specifies three levels of review for their grievance procedure. The first level is through the health carrier only, and the second level involves external peer review by the health carrier. If after completing the second level you receive an adverse determination and your disagreement is about an issue of medical care, you may appeal to the third level, which is independent review.

## The Independent Review Process:

Whom to contact:	Missouri Department of Insurance (MDI), Division of Consumer Affairs
Who can appeal:	You or your health plan
What you can appeal:	Denials of coverage for services the health plan determines do not meet requirements for medical necessity, appropriateness, health care setting, or level of care or effectiveness.
When you can appeal:	You may file after denial for coverage has been appealed and at any time through all levels of the health plan's internal process.
What to send:	Written request
What you must pay:	No charge
What will happen:	<ol style="list-style-type: none"><li>1. MDI checks that your request is appropriate for independent review.</li><li>2. MDI requests you and your health plan to submit all relevant and pertinent information within 20 days (although you may take longer if necessary).</li><li>3. MDI sends the entire request to the independent review organization.</li><li>4. The review organization notifies the Director of MDI of its decision.</li><li>5. The Director decides whether to agree or disagree (either entirely or in part) with the review organization's decision and tells the health plan how to respond. The decision of the Director is binding on the health plan, unless appealed.</li></ol>
When you will get a decision:	The review organization will usually respond within 20 days after it receives all pertinent information.
In urgent situations:	No statutory procedures for an expedited review to the independent review organization. MDI can request the review organization to expedite as a courtesy.

## How to Get More Information

Missouri Department of Insurance, 1-800-726-7390

[www.insurance.state.mo.us](http://www.insurance.state.mo.us)

# Montana

## General Information:

Montana's statute permits any party whose appeal of an adverse determination is denied by the health carrier or managed care entity to seek independent review of that determination by a peer. Montana requires the individual to go through the health plan's internal review process before accessing the independent review process. Montana has few requirements for internal review processes, but health plans are required to notify you and your provider of an adverse determination within 10 calendar days from the date a decision is made regarding routine medical care, or within 48 hours (excluding Sundays and holidays) if the condition qualifies for expedited review.

If you receive an adverse determination, the health plan will send you instructions for the internal appeal or independent review.

## The Independent Review Process:

Whom to contact:	Your health plan
Who can appeal:	You or your authorized representative
What you can appeal:	"Adverse determinations", which are decisions by your health plan that health care services are not appropriate and medically necessary.
When you can appeal:	You may file after the health plan's internal appeals process is exhausted and an appeal of an adverse determination is denied by the health plan. If the internal appeals process is not completed within 60 days of receipt of the request for appeal, the process is interrupted and the case is forwarded for independent review. If delay threatens your life or seriously threatens your health, the internal appeal process may be bypassed.
What to send:	Your health plan will include an explanation of your rights to appeal and instructions on how to initiate an appeal or independent review.
What you must pay:	No charge
What will happen:	You and your health plan may agree on a peer to conduct an independent review. If you are both unable to agree, your case will be forwarded to the independent review organization designated by the Department.
When you will get a decision:	30 days after the review organization receives the case file (unless the review organization requests an extension from the Department).
In urgent situations:	An expedited review will be decided within 72 hours from the date the request is received.

## How to Get More Information

Montana Department of Public Health and Human Services, Quality Assurance Division, 406-444-2037

# Nebraska

## General Information:

As of August 31, 2002, Nebraska did not have an external review program for denials of coverage for services that health plans consider either experimental or not medically necessary.

## How to Get More Information:

Contact your health plan.

# Nevada

## General Information:

As of August 31, 2002, Nevada did not have an external review program for denials of coverage for services that health plans consider either experimental or not medically necessary.

## How to Get More Information:

Contact your health plan.

# New Hampshire

## General Information:

New Hampshire health plans must have written procedures for disputes regarding adverse determinations that provide for a standard review, a second-level grievance review, and expedited grievance review procedures in situations where delay would jeopardize the patient's life, health, or ability to regain maximum function. If you have exhausted your health plan's internal appeal process, you may file for external appeal.

## The External Appeal Process:

Whom to contact:	New Hampshire Insurance Department
Who can appeal:	You or anyone you have given consent to represent you including your health care provider.
What you can appeal:	Denials of coverage for services the health plan determines are not medically necessary or are experimental or investigational. The cost of the denied services is or is anticipated in a 12-month period to be equal to, or in excess of, \$400.
When you can appeal:	You must file within 180 days of the date of the health carrier's second-level denial. Some exceptions allow you to file earlier, such as if the health plan agrees to file earlier or if the health plan does not meet time requirements for decisions.
What to send:	<ol style="list-style-type: none"><li>1. Completed external appeal request form</li><li>2. Copy of letter denying service at final level</li><li>3. Evidence of insurance (e.g., photocopy of insurance card)</li><li>4. Copy of certificate of coverage or policy benefit booklet</li><li>5. Any medical records or other information you want the reviewer to consider</li></ol>
What you must pay:	No charge
What will happen:	<ol style="list-style-type: none"><li>1. Preliminary review by the Insurance Department within 7 days of receipt to determine if the request is complete and eligible for review.</li><li>2. If the request is not complete, you have 10 days to supply the information needed.</li><li>3. If the request is complete, the Insurance Department selects an independent review organization and notifies you and the health plan.</li><li>4. After the appeal is accepted, the insurer must provide all relevant information to you and the review organization within 10 days.</li><li>5. You then have 10 more days to submit new or additional information. You may in some circumstances be permitted to discuss the case with the reviewer by telephone conference.</li><li>6. The record of the case will be closed and no new information may be provided after the second 10-day window.</li></ol>
When you will get a decision:	20 days after the record of the case is closed
In urgent situations:	Expedited review is available if delay would seriously jeopardize your life, health, or ability to regain maximum function and must be completed within 72 hours.

## How to Get More Information:

New Hampshire Department of Insurance, 1-800-852-3416

[www.state.nh.us/insurance/](http://www.state.nh.us/insurance/)

## New Jersey

### General Information:

New Jersey requires you to complete 2 levels of internal appeal to your health plan prior to appealing for external appeal. The informal internal appeal can be initiated by a phone call to the health plan, by writing a letter, or by having your doctor file an appeal. You will receive a response within 5 business days or within 72 hours for an emergency. If you are still denied or restricted coverage, you may file a formal internal appeal either verbally or in writing (your health plan will provide the information you need to make this appeal). You are supposed to receive a response within 20 business days or within 72 hours for urgent or emergency care.

### The External Appeal Process:

Whom to contact:	New Jersey Department of Health and Senior Services
Who can appeal:	You, your doctor, or your authorized representative
What you can appeal:	Denials, reduction, termination, or limitations of covered health care services.
When you can appeal:	After denial for coverage has been appealed through the health plan's internal appeal process or the plan has not responded within the required deadlines, you must file within 60 days after your formal internal appeal is denied.
What to send:	A complete external appeal form (provided by your health plan) which asks for the following information: <ol style="list-style-type: none"><li>1. Name and address of the health plan</li><li>2. Brief description of the pertinent medical condition</li><li>3. Copies of the Informal and Formal Internal Appeal denials</li><li>4. Written medical records release</li><li>5. Copy of your summary of insurance coverage</li></ol>
What you must pay:	\$25 (may be reduced or waived in cases of financial hardship)
What will happen:	<ol style="list-style-type: none"><li>1. The Department will refer your appeal to an independent utilization review organization.</li><li>2. The review organization will evaluate your appeal to determine if it is acceptable.</li><li>3. If your appeal is accepted for further review, you will receive a decision within 30 business days after all information needed for review has been received.</li></ol>
When you will get a decision:	30 business days after all information needed for review has been received
In urgent situations:	If your appeal involves care for an urgent or emergency case, you will receive a response within 48 hours.

### How to Get More Information:

New Jersey Department of Health and Senior Services, Office of Managed Care,  
888-393-1062 (in-state only) or 609-633-0660  
[www.state.nj.us/health](http://www.state.nj.us/health)

# New Mexico

## General Information:

New Mexico has two types of appeals processes – one for utilization issues (External Review), and a separate process for non-utilization issues.

For utilization issues, New Mexico provides for an internal review, which consists of two steps with your health plan prior to initiating the external review process. The internal review must be complete in whole within 20 working days.

## The External Review Process:

Whom to contact:	New Mexico Superintendent of Insurance, State Corporation Commission
Who can appeal:	You or your provider with written consent
What you can appeal:	Denials of coverage for services the health plan determines are not medically necessary or a coverage benefit.
When you can appeal:	You must file within 20 working days after receiving the written notice from the health plan's internal review. An expedited external review may be appealed concurrently with the internal appeal.
What to send:	Completed request form, including a medical records release.
What you must pay:	No charge
What will happen:	<ol style="list-style-type: none"><li>1. The Division of Insurance will complete the external review within 20 working days or 72 hours for expedited reviews.</li><li>2. If the case is not accepted for an external review hearing the Superintendent will notify the enrollee.</li><li>3. If the case is accepted, the Superintendent schedules the external hearing immediately.</li><li>4. A panel of independent hearing officers will hear the case. The panel will consist of two physicians and one attorney.</li><li>5. The panel will make a recommendation to the enrollee, health plan, and Superintendent after the hearing.</li><li>6. The Superintendent will evaluate the panel's recommendation and make a decision based on the evidence and the panel's recommendation and issue an appropriate order.</li><li>7. The order is binding on the health plan and the grievant.</li><li>8. Both the grievant and the health plan may take the case to district court.</li></ol>
When you will get a decision:	20 days after receipt of the request for external review and all necessary documentation.
In urgent situations:	Within 72 hours for an emergency

## How to Get More Information:

Managed Health Care Hot Line, 877-673-1732 or 505-827-3928

# New York

## General Information:

In New York, health plans must respond to internal appeals according to a specified timeframe. If the internal appeal timeframe is not met, the service must be provided by the health plan and an external appeal will be unnecessary. (Health plans must determine expedited appeals within 2 business days and standard appeals within 60 days). If you are denied coverage for requested services your health plan considers either (1) not medically necessary, or (2) experimental or investigational, you may apply for an external appeal.

## The External Appeal Process:

Whom to contact:	New York State Insurance Department
Who can appeal:	You, or your authorized representative, including your provider
What you can appeal:	Denials of coverage for services the health plan determines are not medically necessary or are experimental or investigational.
When you can appeal:	You must request an external appeal within 45 days from receipt of the final adverse determination from the first level of internal appeal with your health plan or within 45 days of receipt of a letter from your health plan agreeing to waive the internal appeal process.
What to send:	Completed application (a physician's statement is required for Experimental/Investigational appeals) and a copy of the adverse determination letter or a letter from the health plan waiving the appeal.
What you must pay:	Up to \$50 (the fee is waived under certain conditions). The fee is returned to the patient if the health plan denial is ultimately overturned.
What will happen:	The Insurance Department will: 1. Review the appeal request within 5 business days. 2. Assign the request to an external review agent if the request is eligible and complete.  The external review agent will: 1) Have a medical expert (or experts) review the appeal. 2) Determine the outcome.
When you will get a decision:	30 days (plus 5 business days if additional information is requested)
In urgent situations:	An expedited appeal will be reviewed by the Insurance Department within 24 hours and the outcome determined by the external review agent within 3 days.

## How to Get More Information:

New York State Insurance Department Hotline, 1-800-400-8882

[www.ins.state.ny.us](http://www.ins.state.ny.us)

# North Carolina

## General Information:

North Carolina requires health plans to have an internal appeal and grievance process for noncertification decisions. In general, a request for external review shall not be considered until the insured has exhausted the insurer's internal appeal and grievance process. If denied coverage for requested services that your health plan considers not medically necessary, the insured may request an external review.

## The External Review Process:

Whom to contact:	North Carolina Department of Insurance, Healthcare Review Program
Who can appeal:	Insured or authorized representative
What you can appeal:	External review is available when your health plan denies coverage for services or requested services on the grounds that they are not medically necessary.
When you can appeal:	You can file a request for external review within 60 days of receiving notice of your health plan's final decision from the highest level of appeal offered, or for expedited external review, within 60 days of receiving either the initial denial or decision on appeal.
What to send:	<ol style="list-style-type: none"> <li>1. Completed external review request form, unless expedited request (which can be made orally or in writing),</li> <li>2. Copy of notice of final determination denying coverage from insurer,</li> <li>3. Signed medical authorization release form, and</li> <li>4. Copy of your health insurance card.</li> </ol>
What you must pay:	No charge
What will happen:	<p>The Healthcare Review Program will:</p> <ol style="list-style-type: none"> <li>1. Conduct a preliminary review of your request to determine eligibility for external review. Within 10 business days after requesting external review, you will receive notification whether the request is complete and whether it has been accepted for review. Your health plan and provider will be notified at the same time.</li> <li>2. If accepted for review, your case will be assigned to an independent review organization (IRO).</li> <li>3. For a standard review, you may provide written information to the IRO within 7 days after the date of notice of acceptance. That same information must be provided to your health plan by the same means as it was provided to the IRO.</li> </ol> <p>The Independent Review Organization will:</p> <ol style="list-style-type: none"> <li>1. Have a medical expert(s) review the case.</li> <li>2. Make a determination in writing in which you, your provider, and insurer are notified of the decision.</li> </ol>
When you will get a decision:	External review is performed on either a standard or expedited timetable, depending on which is requested and on whether medical circumstances meet the criteria for expedited review. A decision is issued by the IRO within 45 days of the Healthcare Review Program receiving the request for standard reviews and 4 days for expedited reviews.
In urgent situations:	An expedited external review of a noncertification decision (denial) may be available only when having first completed your health plan's internal appeal process (even on an expedited basis) or receiving a standard external review through the Healthcare Review Program would put your life, health, or recovery in serious jeopardy.

## How to Get More Information:

North Carolina Department of Insurance Healthcare Review Program

In State toll free: 877-885-0231, Local: 919-715-1163; [www.ncdoi.com](http://www.ncdoi.com)

## North Dakota

### General Information:

As of August 31, 2002, North Dakota did not have an external review program for denials of coverage for services that health plans consider either experimental or not medically necessary.

### How to Get More Information:

Contact your health plan.

# Ohio

## General Information:

Ohio requires HMOs to have internal procedures to handle disagreements regarding coverage for health services. If payment is denied, your provider may first request a reconsideration (with your consent). If you receive an adverse determination, you may then appeal through your health plan's internal procedures, and can expect a decision within 60 days. If the seriousness of your condition requires an expedited review, you will receive a decision within 7 days after your request is received.

If after appeal you still are denied payment for health services, you may request an external review. If your health plan does not complete its internal review within the required time frame, you may also request an external review. If your dispute concerns whether or not the service is covered under the contract, your case will be handled by the Superintendent of Insurance. If your dispute concerns medical issues, it will be sent to an external review organization.

Ohio's external review process applies to both HMOs and traditional insurance. Some traditional insurance plans have an internal review process that must be completed prior to applying for external review.

## The External Review Process:

Whom to contact:	Your health plan
Who can appeal:	You, your provider (with consent), or your authorized representative
What you can appeal:	Denials, reductions, or terminations of coverage for services the health plan determines are (a) not medically necessary, (b) determined to be experimental or investigational and the enrollee has a terminal condition, or (c) questions of contract coverage (these are reviewed by the Superintendent of Insurance.)
When you can appeal:	After denial for coverage has been appealed through all levels of the health plan's internal process, within 60 days from receipt of the final adverse determination. Unless your case qualifies for expedited review, your cost for the denied services must exceed \$500. For expedited review, your provider must explain why your medical condition is eligible. Questions of contract coverage and experimental/investigational reviews are not subject to the \$500 certification.
What to send:	<ol style="list-style-type: none"> <li>1. A written request for standard reviews, or a phone call or fax followed up by written confirmation for expedited reviews.</li> <li>2. If review is based on medical necessity, you must submit a certification from your provider that the cost to you for these services will exceed \$500 (if applicable).</li> </ol>
What you must pay:	No charge
What will happen:	<p>For appeal of denial based on medical necessity or because the service is considered experimental or investigational and the enrollee has a terminal illness, you need to contact your health plan, who will then contact the Superintendent.</p> <ol style="list-style-type: none"> <li>1. The Superintendent will randomly assign two independent review organizations to your case.</li> <li>2. Your health plan will choose one of the independent review organizations.</li> <li>3. The review organization will evaluate the information submitted and make a decision based on safety, efficacy, appropriateness, and cost effectiveness.</li> </ol> <p>For appeal of denial based on question of contract coverage, you need to contact the Superintendent.</p> <ol style="list-style-type: none"> <li>1. The Superintendent will determine if your service is covered and notify your health plan. If the case involves medical issues that would cost you \$500 or more, the Superintendent will notify your health plan to either cover the service or provide an external review. If the case would cost less than \$500, the case does not qualify for external review and is outside the Department's jurisdiction.</li> </ol>
When you will get a decision:	The Independent Review Organization has 30 days to complete the review for a standard review and 7 days for an expedited review. There is no time frame in which the Superintendent must complete the review.

In urgent situations:	Expedited review is available if delay will place your health in serious jeopardy, seriously impair your body function, or cause serious dysfunction of any body part or organ. You will receive a decision within 7 days of filing for review.
-----------------------	---

How to Get More Information:

Consumer Hotline, 1-800-686-1526  
[www.ohioinsurance.gov](http://www.ohioinsurance.gov)

# Oklahoma

## General Information:

Oklahoma health plans are required to establish internal review procedures that are approved by either the Department of Insurance or the Board of Health (depending which agency regulates the health plan). If you have exhausted the internal review process, then you may request external review.

## The External Review Process:

Whom to contact:	Your health plan
Who can appeal:	You or your authorized representative
What you can appeal:	Denials of coverage for services costing more than \$1,000 that the health plan determines are not medically necessary, medically appropriate, or medically effective.
When you can appeal:	After denial for coverage has been appealed through all levels of the health plan's internal process, you must file within 30 days from receipt of the final adverse decision.
What to send:	A written request
What you must pay:	\$50 (refunded if the external reviewer decides in your favor). Additionally, some HMOs refund all external review fees regardless of outcome.
What will happen:	<ol style="list-style-type: none"><li>1) Your health plan will select an independent review organization.</li><li>2) The Department of Health will tell you which review organization was selected.</li><li>3) If you have reason to object to the selected reviewer, you may notify the Department within 3 days and the Department may allow you to select a different reviewer.</li><li>4) Within 5 days of final reviewer selection, you must provide:<ol style="list-style-type: none"><li>a. A written request for external review including the reasons why you are requesting the review,</li><li>b. A copy of the decision to deny coverage from your health plan</li><li>c. A medical records release.</li></ol></li><li>5) After receiving your information, the review organization will conduct a preliminary review to determine if your case is eligible for external review.</li><li>6) If your case is accepted for external review, your health plan will provide documentation within 5 business days of notification that the case has been accepted.</li><li>7) Within 5 days of receiving the health plan documentation, the review organization will request any additional information it needs from you. You will have 5 business days to provide the information or explain why it can't be provided.</li><li>8) The review organization will decide your case.</li></ol>
When you will get a decision:	Within 30 days after acceptance of the request for external review and receipt of all documentation.
In urgent situations:	In an emergency that will jeopardize your life or health, an expedited review is available and you will receive a decision within 72 hours.

## How to Get More Information:

Managed Care Systems, 405-271-6868

[www.health.state.ok.us](http://www.health.state.ok.us)

# Oregon

## General Information:

Oregon established an external review program effective July 1, 2002. Oregon law requires you to complete up to 3 levels of your health plan's internal grievance procedure before applying for external review, unless your health plan agrees to waive this requirement. Although you apply through your health plan, the Oregon Insurance Division selects the Independent Review Organization (IRO).

In addition to appeals based on disagreements about medical necessity and whether a procedure is experimental or investigational, Oregon allows appeals regarding "continuity of care." Oregon's continuity of care rules require managed care plans to continue to provide coverage with a particular provider for a limited period of time if that provider leaves an enrollee's health maintenance organization (HMO) network while the insured is undergoing an active course of treatment which the provider and patient consider medically necessary.

## The External Review Process:

Whom to contact:	Contact your health plan
Who can appeal:	Anyone can request external review who is covered by a health benefit plan other than Medicare, the Oregon Health Plan, and employer self-insured plans.
What you can appeal:	You can appeal denials of coverage for services that the health plan determines are not medically necessary, are considered experimental or investigational, or that require continuity of care when a provider leaves your HMO.
When you can appeal:	After denial for coverage has been appealed through up to 3 levels of the health plan's internal process; you must request external review within 180 days from receipt of the final adverse decision.
What to send:	Send a written request for external review. If the patient is in serious danger of life-threatening injury or impairment pending a 30-day review process, the request should state "expedited review" and include testimony from a health care professional as to the potential danger.
What you must pay:	No charge: all costs are paid by the insurer
What will happen:	Your health plan will forward your request for external review to the State of Oregon's Insurance Division within 2 days. The Consumer Advocate Liaison will assign your case to an IRO and tell you which IRO will review your case. If there is a conflict of interest, you may challenge the choice of IRO within 2 days of receiving the notice by contacting the Consumer Advocate Liaison.  The IRO will <ol style="list-style-type: none"> <li>1. Determine if your request qualifies for external review.</li> <li>2. Accept additional information from you, your provider, or your health plan within 7 days.</li> <li>3. Review your case and notify you and your health plan of its decision.</li> </ol>
When you will get a decision:	For a standard review, you will receive a decision from the IRO within 30 days of your request for independent review.
In urgent situations:	You, your provider, or your health plan may submit additional information within 24 hours of an expedited request. An expedited review produces a decision within 3 days of your request.

## How to Get More Information:

Oregon Department of Consumer & Business Services, Insurance Division, 503-947-7269

[www.oregoninsurance.org/docs/consumer/health.htm](http://www.oregoninsurance.org/docs/consumer/health.htm)

# Pennsylvania

## General Information:

Act 68, effective January 1, 1999, created new managed care protections, including new procedures for complaints and grievances. The Act is jointly administered by the Department of Health and the Insurance Department. The Department of Insurance created new regulations effective March 11, 2000, and the Department of Health created new regulations effective June 9, 2001.

Pennsylvania distinguishes between grievances and complaints, and has separate procedures for each type of problem. A *grievance* is any request to have a review of a denial of a covered health service on the basis of medical necessity or appropriateness. A *complaint* relates to most other problems regarding health plan operations, quality of care or service, contract exclusions, or covered benefits.

Problems are initially filed with the health plan, which usually decides if the issue is a grievance or a complaint. If grievances are not satisfactorily resolved in their two-step process, they can be appealed for review by an independent utilization review organization. If complaints are not satisfactorily resolved in a two-step process with the plan, they may be appealed to either the Department of Health or the Insurance Department.

## The External Grievance Appeal Process:

Whom to contact:	Your health plan
Who can appeal:	You or your provider (with written permission), or your authorized representative If your provider files the grievance, he or she will be responsible for the cost of the review if the denial is upheld by the independent utilization review organization.
What you can appeal:	Denials of coverage for services the health plan determines are not medically necessary or appropriate.
When you can appeal:	After denial for coverage has been appealed through the second level of the health plan's internal process, you must appeal within 15 days from receipt of health plan's decision.
What to send:	1. Enrollees name, address, and phone number 2. Name of health plan 3. Enrollee ID number 4. Copy of denial letter 5. Brief description of the problem 6. Any additional material that supports your position.
What you must pay:	Up to \$25
What will happen:	1. The health plan will notify the state. 2. The state will assign your case to an independent utilization review organization. 3. The review organization will evaluate your case and provide written notice to you, the health plan, and the Department of Health.
When you will get a decision:	In about 60 days
In urgent situations:	If delay will jeopardize your life, health, or ability to regain maximum function, you should work with your plan to facilitate an expedited review, which will result in a 48 hours turn-around time.

## How to Get More Information:

Complaints or Grievances: Bureau of Managed Care, 1-888-466-2787

Complaints: Pennsylvania Insurance Department, 1-877-881-6388

# Rhode Island

## General Information:

Rhode Island specifies that health plans provide two levels of internal appeal. If you receive an adverse determination after completing the second level of internal appeals, you may apply for external review.

## The External Review Process:

Whom to contact:	The review agent that rendered the adverse decision
Who can appeal:	You, your provider, or your authorized representative
What you can appeal:	Adverse decisions, which are decisions by a review agent not to certify a health care service.
When you can appeal:	After denial for coverage has been appealed through the 2 <sup>nd</sup> level of the health plan's internal process, you must file within 60 days from receipt of the 2 <sup>nd</sup> level appeal denial.
What to send:	Notices of adverse decisions will contain instructions for how to initiate the next level of appeal.
What you must pay:	Half of the cost of the review. The cost depends on which external review agency is used. If the adverse decision is overturned, your payment will be refunded.
What will happen:	<ol style="list-style-type: none"><li>1. You will select the external review agency.</li><li>2. The review agent will provide information to the external appeals agency within 5 days of receiving the initial notification of appeal.</li><li>3. The external appeals agency will review the information and make a determination. The appeal will not be processed until the fee and all required documentation is received.</li></ol>
When you will get a decision:	Within 10 business days
In urgent situations:	In an emergency, an expedited appeal will be reviewed and decided by the external appeals agency within 2 days.

## How to Get More Information:

Contact your health plan or utilization review agent for information concerning appeals.

Rhode Island Department of Health, 401-222-6015

[www.health.state.ri.us](http://www.health.state.ri.us)

# South Carolina

## General Information:

South Carolina's regulations for external review went into effect 1/1/2002.

## The External Review Process:

Whom to contact:	Your health plan
Who can appeal:	You or your authorized representative
What you can appeal:	Denied health services that are not considered medically necessary, effective, appropriate, at the appropriate level of care, or provided in the appropriate setting. For conditions that are life threatening or seriously disabling, services considered experimental or investigational may be appealed. The amount payable for covered benefits must be at least \$500.
When you can appeal:	For a standard review, you must apply within 60 days after receiving notice that your request for services has been denied. You must apply within 15 days for an expedited review.
What to send:	Request an external review in writing.
What you must pay:	No charge
What will happen:	<p>Within 5 business days of receiving your request for external review, your health plan will either:</p> <ol style="list-style-type: none"><li>1. Assign your case to an independent review organization and send documentation to the review organization, or</li><li>2. Notify you in writing why your request does not meet the requirements for external review.</li></ol> <p>If your health plan does not send the documentation, the review organization may terminate the review and reverse the adverse determination or final adverse termination.</p> <p>Within 5 business days of receiving the request for external review, the review organization will evaluate whether or not the necessary information has been received and notify you if additional information is needed. You must also submit additional information and documentation to support your case within 7 business days after receiving this notification.</p> <p>In general, the review organization will evaluate the documentation and make a decision. If your appeal concerns an experimental or investigational treatment, the review organization will select a review panel and the reviewers will submit written opinions. The review organization will then make a decision to uphold or reverse your health plan's determination. Decisions regarding denials of experimental or investigational treatments must be based on the recommendation made by the majority of the panelists.</p>
When you will get a decision:	Within 45 days after the review organization receives the request from your health plan.
In urgent situations:	An expedited review is available if the patient has a serious medical condition or is requesting continued care after receiving emergency treatment. You must apply for expedited review within 15 days of receiving notice that your request for services has been denied. A decision will be made no more than 3 business days after the request was received by the health plan.

## How to Get More Information:

Department of Insurance, Consumer Services Division, 1-800-768-3467 or 803-737-6180

[www.doi.state.sc.us](http://www.doi.state.sc.us)

## South Dakota

### General Information:

As of August 31, 2002, South Dakota did not have an external review program for denials of coverage for services that health plans consider either experimental or not medically necessary.

### How to Get More Information:

Contact your health plan.

# Tennessee

## General Information:

For HMOs, Tennessee requires consumers to use their health plan's internal grievance process prior to asking the Commissioner of the Insurance Division for a review. Health plans must provide not only an initial review, but also a reconsideration of the review if you request one.

If you are unsatisfied with the results of your review you may either ask your health plan for an independent review, which can cost \$50, or can ask the Insurance Division to review the decision, which is available at no charge. The two processes use different rules and timelines; independent review through the health plan is described below. HMO grievances filed with the Insurance Division are reviewed by Division staff, which includes a physician.

## The Independent Review Process:

Whom to contact:	Your health plan
Who can appeal:	You or your authorized representative
What you can appeal:	Denials of coverage for services the health plan determines are not medically necessary or are experimental. The cost of the proposed service to the health plan must be at least \$500.
When you can appeal:	After completing the HMO internal grievance process, within 60 days of receiving final notification that coverage will be denied.
What to send:	A written letter including any pertinent documentation
What you must pay:	Up to \$50 for independent review
What will happen:	<ol style="list-style-type: none"><li>1. Your health plan has 5 days to provide all pertinent information to the independent review entity.</li><li>2. The independent review entity will request any additional information from you and your doctor within 5 days of receiving the information from the health plan.</li><li>3. The independent review entity will review your case and make a decision.</li></ol>
When you will get a decision:	Within 30 days of receiving the request for review. (The expert may request an extension of 5 additional days to consider additional information.)
In urgent situations:	For life-threatening conditions, a decision will be made within 5 days.

## How to Get More Information:

Tennessee Department of Commerce and Insurance, 615-253-3055

# Texas

## General Information:

Texas requires health plans and Utilization Review Agents (URAs) for those plans to have an internal appeal procedure. If you have exhausted your plan or URA's internal appeal procedure and are still denied coverage for care because the plan or URA regards the care as not medically necessary or appropriate, then you may file for independent review by an Independent Review Organization (IRO). You cannot be required to exhaust your plan's internal appeal process if you have a life-threatening condition and can request the review immediately. If the IRO disagrees with the health plan or URA's denial, your health plan will be required to pay for the requested care.

You are not eligible for an independent review if the denial is not based on medical necessity (i.e., the contract does not cover the service or treatment requested or the treatment is experimental). You may, however, appeal to the health plan or you may file a complaint with the Department of Insurance. You also may not request an independent review if you have already received the services and your health plan then determines that the treatment was not medically necessary or appropriate (retrospective review). However, you (or, with your consent, your provider) are entitled to appeal the denial of the claim to the health plan.

## The Independent Review Process:

Whom to contact:	Your health plan or its utilization review agent
Who can appeal:	You, your provider, or your authorized representative (although only you or your legal guardian may sign a medical records release form).
What you can appeal:	Prospective or concurrent denials of coverage for services that the health plan or its utilization review agent determines are not medically necessary or appropriate.
When you can appeal:	After denial for coverage has been appealed through the health plan's or its utilization review agent's internal process, or immediately to the IRO if you have a life-threatening condition. There is no time limit.
What to send:	A completed independent review request form (the health plan or its utilization review agent is required to provide you with this form at the time it denies services and again if your appeal is denied). Send to your health plan or its utilization review agent at the address or fax number listed at the bottom of the request form.
What you must pay:	No charge
What will happen:	<ol style="list-style-type: none"><li>1. The health plan or its utilization review agent will immediately notify the Department of Insurance that you have requested an independent review.</li><li>2. The Department will randomly assign your case to an independent review organization within one business day of receiving a complete IRO request.</li><li>3. The Department will notify the patient and the providers involved about the assignment.</li><li>4. The health plan will send all pertinent information to the review organization by the 3<sup>rd</sup> day after receiving your review request.</li><li>5. <u>The review organization will make a determination.</u></li></ol>
When you will get a decision:	Either 15 business days after receiving necessary information or 20 business days after receiving your request for independent review.
In urgent situations:	If your case involves a life-threatening condition, the review organization will decide your case within 8 calendar days.

## How to Get More Information:

IRO Information Line, 888-834-2476 (322-3400 in Austin)  
Consumer Help Line, 1-800-252-3439 (463-6515 in Austin)  
[www.tdi.state.tx.us](http://www.tdi.state.tx.us)

# Utah

## General Information:

The external review process in Utah was effective as of January 1, 2001.

## The Independent Review Process:

Whom to contact:	Your insurance carrier
Who can appeal:	You or your authorized representative
What you can appeal:	Adverse benefit determinations of medical necessity.
When you can appeal:	You may appeal within 180 calendar days from the date of the final review decision of the internal review process
What to send:	Independent reviews need to be requested in writing, while expedited reviews may be submitted orally or in writing. You will want to provide the insurer with as much information as possible so the independent review organization can conduct a complete and fair review.
What you must pay:	No charge
What will happen:	<p>Your request for a review will be handled as an independent review, unless there is an urgent medical situation and then it will be handled as an expedited review.</p> <p>Independent reviews:</p> <ol style="list-style-type: none"><li>1. You must exhaust the insurers internal review process unless you and the insurer mutually agree to waive the internal process.</li><li>2. You must send your insurer a written request for an independent review within 180 days from the date of the final internal review decision.</li><li>3. Your insurer will select an Independent Review Organization to conduct the review.</li><li>4. Your insurer will send you notification of the Independent Review Organization's decision. This notification will include the reasons for the decision, reference to the specific plan provision on which the decision is based.</li><li>5. The independent review decision is binding and final.</li></ol> <p>Expedited reviews:</p> <ol style="list-style-type: none"><li>1. You may submit a request for an expedited review either orally or in writing. If your insurer receives an oral request for an expedited review, the insurer will send you a written confirmation of the request within 24 hours.</li><li>2. Your insurer will select an Independent Review Organization to conduct the review.</li><li>3. Your insurer will send you notification of the Independent Review Organization's decision. This notification will include the reasons for the decision, reference to the specific plan provision on which the decision is based.</li><li>4. The expedited review decision is binding and final.</li></ol>
When you will get a decision:	Within 30 days for an Independent Review of a pre-service claim, and within 60 days for a post-service claim
In urgent situations:	The insurer will notify you as soon as possible, but no later than 72 hours after receiving your request for an expedited review.

## How to Get More Information:

Utah State Insurance Department,  
801-538-3805 (Salt Lake City), 1-800-439-3805 (other Utah areas), 801-538-3826 (TDD)  
[www.insurance.utah.gov](http://www.insurance.utah.gov)

# Vermont

## General Information:

Vermont health plans must follow state rules regarding internal appeals. Generally, if you have exhausted the internal appeals for your health plan, you are eligible to request an external appeal (although there are different rules for mental health and substance abuse services).

External appeals for mental health or substance abuse services are decided by the Independent Panel of Mental Health Providers. External appeals for other services are decided by independent review organizations. You can initiate an external appeal for any type of health care service by calling the Division of Health Care Administration of the Department of Banking, Insurance, Securities and Health Care Administration at 800-631-7788 or 802-828-2900.

The Vermont Office of Health Care Ombudsman (800-917-7787 or 802-863-2316) can assist consumers with appeals and other health insurance issues.

## The Appeal Process (not for mental health or substance abuse):

Whom to contact:	The Division of Health Care Administration of the Department of Banking, Insurance, Securities and Health Care Administration
Who can appeal:	You or a representative of your choice
What you can appeal:	Denials, reductions, or terminations of coverage for claims of at least \$100: <ol style="list-style-type: none"> <li>1. For covered services the health plan determines are not medically necessary.</li> <li>2. Limitations on selection of providers that are inconsistent with laws, regulations, or plan limits.</li> <li>3. Determined to be experimental or investigational, or an off-label use of a drug.</li> <li>4. <u>Medically-based determination of a pre-existing condition.</u></li> </ol>
When you can appeal:	After denial for coverage has been appealed through all levels of the health plan's internal process, you must file within 90 days from receipt of the written adverse determination.
What to send:	<ol style="list-style-type: none"> <li>1. A completed request for appeal form.</li> <li>2. The filing fee (check or money order) or request for waiver or reduction of fee.</li> </ol>
What you must pay:	\$25 (the fee is waived under certain conditions)
What will happen:	<ol style="list-style-type: none"> <li>1. The Division will evaluate the request and determine whether or not it qualifies for external review within 5 days.</li> <li>2. The Division will contact you regarding whether or not your request is accepted for review.</li> <li>3. If your request is accepted for review, the Division assigns your case on a rotating basis to an independent review organization.</li> <li>4. The Division will ask you and your health plan to send it the pertinent documentation within 10 days. Your health plan may request an extension of up to 10 days for good cause. You may request an extension for any reason.</li> <li>5. The Division will send you and your health plan the documentation provided by the other party. You and your health plan have 3 days from receiving the information to send a response to the Division.</li> <li>6. After the documentation and responses have been received, the Division will send all of the documentation to the independent review organization assigned to your case.</li> <li>7. The review organization will evaluate the information. You may have a telephone conference with the review organization and the health plan if you requested this on your application.</li> </ol>

When you will get a decision:	30 days from the review organization's receipt of the appeal. The review organization may request an extension for circumstances beyond its control, including receipt of additional information after it has received the appeal.
In urgent situations:	There is an expedited process in emergency or urgent care situations. An expedited appeal will be immediately considered, documentation must be submitted to the Division, and a review organization assigned within 48 hours of acceptance. The review organization will respond within 5 days, unless it determines that your case is not urgent.

How to Get More Information:

Division of Health Care Administration, 1-800-631-7788 (in Vermont), 802-828-2900

# Virginia

## General Information:

Virginia health plans must receive approval of their internal appeal processes from the both the Virginia Bureau of Insurance and the Department of Health.

The Virginia Bureau of Insurance has an ombudsman that is available to help you prepare an internal appeal.

## The External Appeal Process:

Whom to contact:	Virginia Bureau of Insurance (BOI)
Who can appeal:	You, your provider (with your consent), or your authorized representative
What you can appeal:	Denials of coverage for services the health plan determines are not medically necessary or involve experimental or investigative procedures. The cost of the denied services must exceed \$300.
When you can appeal:	After denial for coverage has been appealed through all levels of the health plan's internal process or the plan, you must file within 30 days of the final decision to deny coverage.
What to send:	A completed appeal form (you can call the ombudsman for help)
What you must pay:	\$50 (the fee may be waived for financial hardship and is refunded if you are not eligible)
What will happen:	<ol style="list-style-type: none"><li>1. The BOI will review your appeal to verify eligibility.</li><li>2. The BOI will select an independent healthcare review organization.</li><li>3. You, your physician, and the health plan will be asked to provide pertinent information within 20 working days.</li><li>4. The review organization will recommend a decision.</li><li>5. The Commissioner of Insurance will review the recommendation to assure that it is not arbitrary or capricious.</li></ol>
When you will get a decision:	30 working days after the review organization receives all pertinent information.
In urgent situations:	An expedited appeal is available in an emergency or if required by an emergency medical condition. The BOI will decide if your situation warrants an expedited appeal, and, if so, the review organization will decide your case within 5 working days after the review organization receives all pertinent information.

## How to Get More Information:

State Corporation Commission Bureau of Insurance, 1-800-552-7945 (in Virginia only), 804-371-9206 TDD  
[www.state.va.us/scc/division/boi](http://www.state.va.us/scc/division/boi)

# Washington

## General Information:

Washington requires each health plan to have an internal grievance process of appeals for either complaints or limitations in services. These appeals must be resolved within 30 days (or within 72 hours if delay would seriously jeopardize your life, health, or ability to regain maximum function). After exhausting your health plan's internal appeals you may request an independent review.

While disputing limitations in services, you may request that your health plan continue to provide service. If the independent review is ultimately decided in favor of your health plan, you may be responsible for the cost of this continued service.

## The Independent Review Process:

Whom to contact:	Your health plan
Who can appeal:	You or your authorized representative
What you can appeal:	Denials, modifications, reductions, or terminations of either coverage or payment for health care services.
When you can appeal:	After you have exhausted your health plan's internal grievance procedure and have received an unfavorable decision, or if your health plan has exceeded the timelines for the internal procedure without good cause.
What to send:	Oral or written request. Each carrier must provide a clear explanation of the process upon request, upon enrollment to new enrollees, and annually to enrollees.
What you must pay:	No charge
What will happen:	<ol style="list-style-type: none"><li>1. Your health plan will select a certified independent review organization from the Insurance Commissioner's designated rotational registry.</li><li>2. Your health plan will provide the pertinent documentation to the review organization within 3 business days of receiving your request for review.</li><li>3. The review organization will make a decision.</li></ol>
When you will get a decision:	Either 15 days after the review organization receives all necessary information or 20 days after the request for review, whichever is earlier. (In exceptional circumstances, the review organization may be allowed 25 days after the request for review.)
In urgent situations:	If delay would seriously jeopardize your health or ability to regain maximum function, you should get a decision within either 72 hours after the review organization receives all necessary information or 8 days after the request for review, whichever is earlier.

## How to Get More Information:

Office of the Insurance Commissioner Consumer Hotline, 1-800-562-6900

[www.insurance.wa.gov](http://www.insurance.wa.gov)

# West Virginia

## General Information:

West Virginia passed the Patients' Bill of Rights in April 2001. External reviews became available to consumers on July 1, 2002. The law provides that a managed care plan may apply for exemption from the state external review process if it already has an external review plan in place and the external review plan has been reviewed during the certification process for the health maintenance organization. The details of applying for external review with those individual plans are governed by the HMO documents, but they approximate the statutory requirements discussed here.

## The External Review Process:

Whom to contact:	West Virginia Insurance Commissioner and the managed care plan
Who can appeal:	You
What you can appeal:	Managed care plan's decision to deny, modify, reduce, or terminate coverage or payment for a health care service. External reviews relate only to questions of whether a health care service is medically necessary or whether a health care service is experimental, and the decision must involve services totaling \$1,000 or more.
When you can appeal:	After exhausting your managed care plan's internal grievance procedure, within 60 days of receiving an unfavorable decision by the managed care plan or 60 days after the managed care plan has exceeded the time periods for grievances without reaching a decision.
What to send:	Request for external review form and release of medical records
What you must pay:	No charge
What will happen:	The Insurance Commissioner will notify the enrollee and the health maintenance organization of the internal review procedure within 7 days, after which the health maintenance organization and the enrollee must forward to the assigned external review organization all relevant documents and information in their possession.
When you will get a decision:	Decisions are due within 45 calendar days from the date of the request for external review. In expedited procedures, the decision must be made within 7 calendar days after the request is received by the Insurance Commissioner.
In urgent situations:	For decisions where delay would place the health of the enrollee or the health of the enrollee's unborn child in serious jeopardy, an expedited review process is provided. For an expedited procedure, the Insurance Commissioner issues a notice within 2 business days and the health maintenance organization and the enrollee must respond with information within 2 business days. An expedited review produces a decision within 7 calendar days of the date the request for review is made.

## How to Get More Information:

Contact your health plan.

# Wisconsin

## General Information:

Wisconsin's independent review law became available to consumers on June 15, 2002. Wisconsin law already requires health plans to establish internal grievance procedures that must be approved by the Commissioner of Insurance.

For independent review, Wisconsin allows you to select the organization that will review your case from a list of certified review organizations.

## The Independent Review Process:

Whom to contact:	Your health plan
Who can appeal:	You or your authorized representative
What you can appeal:	Denials of coverage for services the health plan determines are not medically necessary, appropriate, or effective, services that are not provided in the required health care setting, or services that are experimental. The amount in dispute must exceed \$250.
When you can appeal:	After denial for coverage has been appealed through the health plan's internal process, you must file within 4 months from receipt of the final adverse determination or experimental treatment determination.
What to send:	<ol style="list-style-type: none"><li>1. Written request</li><li>2. The name of the review organization you want to review your case.</li></ol>
What you must pay:	\$25 (if the review organization rules in your favor, even in part, your payment will be refunded)
What will happen:	<ol style="list-style-type: none"><li>1. Your health plan must submit all pertinent documents to the independent review organization within 5 business days of receiving your request.</li><li>2. The independent review organization will request any additional information it needs within 5 business days of receiving the initial documentation from your health plan.</li><li>3. Your health plan will send any additional information within 5 days of receiving the request for additional information.</li><li>4. You or your health plan may also submit additional medical or scientific evidence to each other and the review organization.</li></ol>
When you will get a decision:	Within 30 business days after the last of the data request time limits
In urgent situations:	If the independent review organization determines that the required time limits would jeopardize your life, health, or ability to regain maximum function, an expedited review is available. Information will be submitted by your health plan within 1 day, additional information will be requested within 2 days and then submitted within 2 days, and the review organization will make a decision within 72 hours after the last of the data request time limits.

## How to Get More Information:

1-800-236-8517 (in Wisconsin)

[www.oci.wi.gov](http://www.oci.wi.gov)

# Wyoming

## General Information:

As of August 31, 2002, Wyoming did not have an external review program for denials of coverage for services that health plans consider either experimental or not medically necessary.

## How to Get More Information:

Contact your health plan.