A CONSUMER GUIDE TO HANDLING DISPUTES WITH YOUR PRIVATE OR EMPLOYER HEALTH PLAN

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INTRODUCTION

A growing number of people now get their health care through some form of managed care plan – a health maintenance organization, preferred provider organization, or point-of-service option. And most of the time, these people receive the care they need. But whenever an insurer will pay only for care that is considered medically necessary or has the right to limit that care, the potential for a disagreement exists. The health plan may refuse or limit treatment, sometimes for good reasons. In other cases, a procedure is not covered under the terms of your policy. The cases most likely to end up in dispute are often not clear-cut, such as new treatments that may not be widely available and have unproven therapeutic value.

In 1973, the federal government first authorized what were called federally-qualified HMOs and required them to establish rules and procedures for handling their enrollee's complaints and grievances inside the health plan, known as an "internal review." States legislated similar rules for what were called state-qualified health plans, and in recent years most have gone further, setting up additional procedures outside of the health plan. These "external reviews" or "independent reviews," as they are often called, provide an unbiased way to resolve disputes between patients and their health plans. An external review is a reconsideration of a health plan's denial of service, with the review conducted by a person or panel of individuals who are not part of the managed care organization. Today 40 states plus the District of Columbia have legislated such procedures.[1] Anyone enrolled in a managed health care plan should be familiar with their plan's internal review process and any external review program in their state in case problems later arise.

[1] This Guide's total for the number of states with external review programs may differ from the total in other studies because of the different ways of defining what constitutes an external review program. This Guide includes state external review programs that provide an independent review of health plan denials of coverage on the basis that the service was not medically necessary or was experimental.

This guide will help you navigate your plan's internal grievance procedure, as well as your state's external review. The guide is generally not applicable for resolving disputes if you have Medicare or Medicaid coverage. The first section, "Know Your Coverage," is the starting point. Many disputes arise because people don't know what is or is not covered by their insurance policies, and you can avoid a lot of hassle by knowing what is allowed. There may be referral or money rules that you need to follow. At the end of this section, we present questions to help you diagnose your coverage and dig into the important details.

The next section, "Appealing Through Your Plan," outlines the procedure that plans require, and the third section "Getting an Independent Opinion – External Reviews in Your State" explains what to expect if you use your state's external review process. The last section, "State-by-State External Review Programs," provides a summary of the important aspects of your state's procedures and who to contact for further information. Even if your state does not have an external review program such as those described in this report, all states require health plans to have internal review procedures.

KNOW YOUR COVERAGE

The best way to avoid the aggravation and anxiety that often accompanies filing a grievance is to know your coverage and follow the health plan's procedures for referrals and approvals. Many disagreements between patients and their insurers occur because patients do not have a clear understanding about how their insurance works or which services it will cover. You need to understand this information BEFORE a problem arises so you will be able to make effective decisions about your care and who will provide it.

If your employer provides health care coverage, you probably received a Summary of Benefits when you first signed up. It will discuss copayments and covered services in language that is easy to understand. This, however, is not the legal document that will prevail should your dispute with the health plan end up in court. All managed care plans exclude many types of services that are not covered under your insurance policy, and these are not likely to be listed in your Summary of Benefits. Commonly excluded services include infertility treatments, injected drugs, or treatments for obesity. Check with your employer's human relations department to see a copy of the "Evidence of Coverage" to learn about services your plan does not cover.

The decision to pay for services that are not included may ultimately depend on whether your employer has what is called a "self-insured" plan. You may think your coverage is from a health plan that is often mentioned in the news, like CIGNA or Aetna U.S. Healthcare, but if you work for a large employer, those health plans may not actually be insuring you. Instead, they may simply process the claims as a third-party administrator for your employer's self-insured plan. These self-insured plans are exempted from state laws (including your state's external review law) by the Employee Retirement Income Security Act of 1974 (ERISA). This means you probably cannot use

your state's external review process and your only recourse will be to file a grievance with the plan. Consult your employer's human resources department to determine if your plan is self-insured.

If you are a Medicare beneficiary receiving benefits from a Medicare HMO, disputes concerning coverage will be handled through Medicare's managed care appeal process. You begin your Medicare appeal by asking the HMO in writing for a reconsideration of your HMO's denial. Plans must respond with initial decisions within 14 days (or 72 hours for expedited appeals).

All appeals that are rejected are automatically forwarded by the plan for independent review to the Center for Health Dispute Resolution (CHDR), a private organization that Medicare contracts with to review cases and decide appeals. The independent review organization also must respond within 14 days (or 72 hours for expedited reviews). If CHDR decides against you and the dispute involves more than $500, you can appeal to an administrative law judge. You can also appeal to the U.S. Department of Health and Human Services Departmental Appeals Board, and a last step is to take your case to federal district court.

If you are enrolled in a Medicaid managed care program, at this time you are eligible to file for a state administrative hearing often called a "Fair Hearing." In some states you must first go through the plan's internal review process prior to filing, and in others you may file without going through the internal process. Although the process may differ in your state, you should start your appeal by calling your Medicaid office or by following procedures provided by your managed care organization.

Understand Your Plan's Rules

Knowing the rules will help you decide whether a dispute is a matter for your plan's own grievance process or for your state's external review.

Referral Rules

Your primary care physician's office may have requirements regarding when and how you get referrals to specialists or other services. If your doctor provides the referral, be sure to ask when the referral will need to be renewed and how to do so. For example, the plan may initially authorize a limited number of visits to a specialist for your condition. If you need more, will you be able to obtain approval over the phone, or will you need to schedule another visit with your primary care physician?

In addition to a referral from your primary care physician, you may also need pre-authorization by the health plan for some services such as surgeries. Often the doctor's office will contact your health plan to obtain this pre-authorization. For some plans you may need to contact the health plan directly; be sure to find out if your doctor will do this. A phone call to the health plan in advance of a surgery to verify that all authorizations are in order is far easier than finding out that paperwork is missing when you show up at the hospital.

Although these details may seem trivial to you now, many disputes arise when payments are denied because the patients did not obtain proper referral and pre-authorizations.

Money Rules

If you have a health plan such as a POS or PPO (described below) that allows you to go to doctors or hospitals that are not part of its network, be aware that the amount the plan is willing to pay for the services you receive may be less than what the doctor or

hospital bills. Health plans have no control over charges made by out-of network doctors or hospitals. If the out-of-network provider charges more than what the health plan claims is reasonable, you will have to pay the difference plus any coinsurance.

For example, POS or PPO plans usually require you to pay coinsurance (often 20 or 30 percent) of their "allowable charge" for services given by providers who are not part of the network. Suppose your out-of-network coinsurance percentage is 20 percent. If the doctor charges $100 for a service and your health plan's allowable charge for that service is only $80, you will pay the $20 difference plus 20 percent of the $80 allowable charge, for a total of $36. Obviously, for complicated procedures and treatments these out-of-network charges add up.

Checklist For Diagnosing Your Coverage

Knowing your coverage will help avoid misunderstandings. Review your plan documents and complete the following worksheet to (1) make sure you understand your coverage and (2) provide you the necessary information in a convenient place you can consult when you need to arrange care. [2]

My insurance coverage is through:

[ ] My employer -- check whether:
    [ ] my plan is subject to state law
    [ ] my plan is NOT subject to state law
[ ] An individually purchased policy
[ ] A group affiliation policy (such as through a local Chamber of Commerce)
[ ] Medicare
[ ] Medicaid
[ ] Other: _____

[2] The external grievance procedure described later in this Guide will not apply to your plan if it is a self-insured plan governed by ERISA.

My insurance plan is a:

[ ] Health maintenance organization (HMO)
An HMO typically requires all your care to be arranged and approved through your primary-care physician. Providers (hospitals, doctors, and therapists) must be part of the HMO network.

[ ] Point-of-service plan (POS)
A POS plan is an HMO that allows you to obtain some services from providers (hospitals, doctors, and therapists) that are not part of the HMO network. Care received outside the network is usually subject to different payment rules.

[ ] Preferred provider organization (PPO)
A PPO plan allows you to use any providers (hospitals, doctors, and therapists) that you want, but you will pay less if you use providers that are part of the PPO network.

Plan number to call if you have a problem:
_____

My primary-care physician is: _____
Physician's phone number: _____

I need a referral from my primary-care physician for:
[ ] Lab and x-ray tests
[ ] Gynecologist (for well-woman exam)
[ ] Gynecologist (for other concerns)
[ ] Pediatrician
[ ] Other specialist visits
[ ] Surgery
[ ] Other: _____

My primary-care physician has the following requirements for obtaining referrals:
[ ] Requires an office visit
[ ] Requires _____ days advance notice
[ ] Other: _____

My primary-care physician can refer me to specialists who:
[ ] are part of his or her group practice
[ ] are on the health plan network list
[ ] are outside of the health plan network *only if there are no similar specialists within the network*
[ ] are outside of the health plan network
[ ] I do not need a referral from my primary-care physician

I have reviewed the Exclusions and Limitations in my Evidence of Coverage. My insurance will not pay for or limits the following services that I may use:

[ ] _____
[ ] _____
[ ] _____
[ ] _____
[ ] _____
[ ] _____

I can use the following hospitals:

_____
_____
_____

What should I do if I need care while I am out of my plan's service area?

For non-urgent care: _____
phone: _____
In an urgent situation: _____
phone: _____
In an emergency: _____
phone: _____

If you have a POS or PPO plan:

Although I can use out-of-network doctors for most services, I cannot use out-of-network doctors for the following services:

[ ] Mental health
[ ] Substance abuse
[ ] Other: _____

[ ] There is a maximum amount that can be spent on out-of-network doctors.
Annual limit $ _____
Lifetime limit $ _____

If I use out-of network providers, I will pay a $_____ annual deductible and _____% coinsurance for charges exceeding the deductible.

APPEALING THROUGH YOUR PLAN

Disputes with health plans arise over whether services are covered, what treatments should be followed, which providers should be used, how much a service should cost, difficulties dealing with providers, or even billing and administrative mistakes. In most cases, your health plan will have an established grievance or complaint procedure to handle these disagreements. Some states even specify how the health plan's internal procedure must be structured, or they require that the procedure be approved by state regulators. Even if you are eligible to use your state's external grievance procedure, you will usually have to exhaust all appeals to your health plan first, so it is important to learn how your plan's internal process works.

Preparing an Informal Complaint

When you have a disagreement with your health plan, your first step is to contact the customer relations department. Although many disagreements will be solved at this level, this may be just the first step in a lengthy process. Start your record-keeping immediately. Assemble a file containing any paperwork you already have (such as bills or physician information) and keep a log of every telephone call you make to the plan. Be sure to record the date and the name of the person you talk to, and take notes about your conversation. Before hanging up, find out what will happen next and when it will happen. For example, if the representative says he or she will have to find out some information and get back to you, ask when you can reasonably expect to receive a reply. Mark that date both in your notes and on your calendar. If you don't hear from the plan by that date, it's time for another phone call.

Preparing a Formal Grievance

If your attempts to deal with the health plan informally are not successful, you will have to file a formal complaint or grievance. Health plan procedures vary, but all will require details submitted in writing. Some plans allow you to initiate the complaint on the telephone, but then will ask you to complete a form and submit it before the process can continue. If your plan does not provide a complaint form, consult the Evidence of Coverage for a description of the complaint process and look for specific information the plan needs to process your complaint. Be sure to provide answers to all questions. You don't want to add to the delay by forgetting to supply crucial information.

Expect to provide the following information in your written complaint:

- Your name, address, telephone number
- Your insurance plan number or group code and member identification number or Social Security number
- Your provider's name
- Description of the service or procedure that you wish covered (for a coverage complaint)
- Information supporting why the service should be covered (for a coverage complaint)
- Recommendations and referrals from your doctor regarding why the treatment or procedure should be covered
- References to the sections of the Evidence of Coverage that apply to your situation

You may have to file your grievance within a specified time period; it is vital that you do so. For example, the health plan may say it must receive your grievance within one year of the date of treatment or within 60 days of date the plan tells you it is denying your claim, whichever comes first.

Grievance Review

Once the plan receives your written grievance, it will investigate the complaint and make a determination setting out what the plan is willing to do. This procedure goes by different names at different health plans; it may be called an Internal Review, a Level I

Appeal, or a Desk Review. The key feature is that this is the first step in the formal plan grievance process.

At this level of review, you may or may not have further contact with the health plan. Some plans allow for informal discussions or consultations between the person making the complaint and the person who is reviewing it. Other plans will review the documentation for your case and notify you only after making a decision.

Response times vary from plan to plan depending on the type of complaint. The plan will usually act more promptly if the service has yet to be provided or if the patient is already in the hospital than if the service has already been given. Some health plans have indicated that they handle the first level of reviews within one business day for services not yet provided, but another responds within 30 days, with a possible delay of 14 additional days if a decision cannot be made due to circumstances outside of its control. Billing and administrative disputes may be handled differently from those involving payment for services.

If your health plan is subject to state law (in other words, it is not exempted by ERISA), it may also need to follow state requirements that specify how quickly a plan resolves a complaint. If your dispute concerns the medical necessity of services to be provided and your health would be seriously jeopardized by waiting for a standard review, you may be eligible for an expedited review and the plan will evaluate your dispute sooner. It is important to know before a crisis hits whether an expedited review is available from your health plan. You also need to know what to do and how the plan must respond.

Grievance Appeal

If you do not agree with the results of the initial investigation, most plans allow you to appeal the decision to a panel of individuals who were not involved in the initial decision. In some cases you will be asked to appear at a hearing to discuss your case; in others you will not. Each health plan has its own requirements for the composition of the panel; it may include physicians, consumers, and/or representatives of the health plan.

Arbitration

If your plan is not subject to state external review requirements, it may require that you submit to arbitration as a final step in its grievance procedure. Arbitration may require that you give up the right to pursue further legal action.

If your plan is subject to state external review requirements, the plan will usually send you a notice that it has denied your appeal along with instructions on how to file for an external appeal.

Checklist For Appealing to Your Health Plan

Who to call: _____
Where to write: _____
_____
_____

When will you receive a response? (List the time periods at each level for your health plan)

1st level _____
2nd level _____
3rd level _____

GETTING AN INDEPENDENT OPINION – EXTERNAL REVIEW IN YOUR STATE

Most states have external review programs, but the details of administering these programs can vary considerably. External review programs often differ in the types of disputes that are eligible for appeal, the process used to resolve the appeal, and the time limits imposed at each step of the process. This section describes the typical characteristics and variations found in states' external review programs; consult the state-by-state tables in this guide to learn specific requirements in your state and who to contact for further information.

Who Can Appeal

As we've noted, state external review laws generally do not apply to plans that are exempted by ERISA or plans that cover Medicare or Medicaid beneficiaries. If you are in a plan exempted by ERISA, you cannot use your state's external grievance procedure. Currently, your only recourse is through the courts. If you are a Medicare beneficiary, you must follow the Medicare external review process described earlier. If you are a Medicaid beneficiary, you have the right to a Fair Hearing; additional rules may apply in certain states.

Sometimes state external review requirements extend beyond health maintenance organizations to include other managed care organizations that perform utilization review. In these states, if your plan is a preferred provider organization or point-of-service option, you may still be eligible to request an external review.

For the most part, you must file an external appeal yourself, although you can sometimes give someone else written authorization to appeal for you. In many states your provider may appeal on your behalf with your written authorization.

What You Can Appeal

Most states require that the issue at stake involve "medical necessity." That means that you and your doctor must believe a particular procedure, treatment, or pharmaceutical is essential for your health and recovery. Health plans, for a variety of reasons, may disagree. For example, a health plan may believe a particular treatment is ineffective for your condition or is unproven, so it won't pay for it.

Sometimes you and your doctor will want a treatment that could be considered experimental or investigational but your health plan will not cover the cost. Most states will allow you to submit this type of dispute to external review. Often this kind of disagreement stems from the coverage that your employer has purchased. Many employers do not want their policies to cover experimental or investigational treatments, and their policies explicitly exclude them. Whether or not you can request external review for disputes regarding experimental or investigational treatments depends on your state. Many states explicitly exclude disputes regarding coverage issues such as experimental treatments. Some state insurance departments will review your request to be sure that it is eligible for external review before sending it on to an external reviewer. Some states clearly indicate that denials of coverage for treatments your health plan says are experimental or investigational may be submitted for external review. Other states do not clearly address the issue and may or may not accept your request for external review. Check the descriptions of state regulations at the end of this guide for details regarding your state.

Several states require that your dispute involve a minimum amount of money, usually from $100 to $500. In other states, your right to appeal a claim is not limited by the amount of money involved.

When You Can Appeal

If you have a dispute over whether your health plan will pay for a particular treatment, you will sometimes have to decide to proceed with treatment before knowing if the plan will pay for it. In most states, you will be able to submit your dispute for external review even if the services have been provided; in others you may submit only cases involving services that have not been provided.

Most states require you to complete all of the steps in your plan's internal grievance procedure before requesting external review. Some states specify time limits for the internal review, and some allow you to file for external review if you have not received a response within the required time. At least one state, New Mexico, allows you file for external review at the same time as an internal appeal if your case presents an emergency.

If you have completed all steps in the internal appeals process, and you have not won your case, you will receive a notice of "adverse determination" or "adverse decision" from your health plan, along with instructions on how to file with the state for external review. You usually must file within a specified period, say 30 to 90 days after receiving the adverse determination, in order to be eligible for external review.

If a delay in receiving services will cause you serious harm, most states have an "expedited review" which will give you a decision in a much shorter period, usually 24 to 72 hours. Your provider must certify that the needed care is an emergency, and sometimes the state agency must agree.

How to Appeal

Every state has a different procedure for handling external reviews. You will usually receive instructions for filing an external appeal when your internal appeal is denied by your health plan. In some states, you will begin the external appeal by

contacting your health plan again. Others require that you contact your state's department of insurance or other state agency to initiate your appeal.

The actual review may be performed by the state agency itself or through an independent review organization hired by the state. Usually you do not have to pay anything for such reviews, though some states charge a nominal amount, usually $25 to $50.

Although some states schedule a hearing and allow you to speak directly with the reviewer, most do not. In many states, it is not clear whether either you or your health plan must accept the decision of external review, or whether you can appeal through the court system.

STATE-BY-STATE EXTERNAL REVIEW PROGRAMS

The following section gives 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 July 2001. For more information, call or access the state web site listed at the bottom of the page. If your state does not have an external review program, check with your health plan about its internal appeal requirements.

State: Alabama

General Information

As of September 30, 2001, 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

State: Alaska

General Information

The Alaska Patient Bill of Rights Law passed in April 2000 but was not effective until 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:	1. Denials of coverage for services the health plan determines are not medically necessary or are experimental or investigational, or 2. Denials of coverage when medical judgment is needed to determine whether or not the service is a covered benefit under the plan, or 3. Denials of coverage based on failure to meet your health plan's internal appeal deadlines.
When you can appeal:	You must make a "timely appeal" in writing.
What to send:	You are allowed to submit evidence related to the issues in dispute. The law requires the External Appeal Agency to consider: 1. The decision and guidelines used to make the decision, 2. Pertinent personal health or medical information, 3. Your provider's opinion, 4. The managed care plan. The external appeal agency may also consider: 5. Reliable and valid studies, 6. Certain conference results, 7. Government treatment guidelines, 8. Government coverage policies, 9. Generally accepted principals of medical practice, 10. Expert opinions, 11. Peer reviews, 12. Community standard of care, 13. Anomalous utilization patterns.
What you must pay:	No charge
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.

How to Get More Information

Contact your health plan.

State: Arizona

General Information

Arizona distinguishes between "denied claims" (for care you have already received) and "denied services" (care you have yet to receive). 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:	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). For denials based on a coverage issue: 1) Within 15 days of receiving the information, the DOI will review and determine if the service or claim is covered under the policy. 2) The DOI will mail a notice of the decision to you, your health plan, and your treating provider. 3) If the DOI cannot make a decision, it may refer the case to an independent review organization. For denials based on medical necessity: 1) Within 5 days of receiving the information, the DOI will send your case to an independent review organization (IRO). 2) The independent reviewer will evaluate the case, make a decision within 21 days, and send a notice of the decision to the DOI. 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.
When you will get a decision:	For standard reviews based on medical necessity: approximately 36 days from the date your request is received. For standard reviews based on coverage issues: within 20 business 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: 800-325-2548
www.state.az.us/id

State: Arkansas

General Information

As of September 30, 2001, 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.

State: California

General Information

California provides an external, independent review process to examine health plan decisions regarding medical necessity and experimental or investigational treatment, as well as disputed health care services for California managed care enrollees and managed Medi-Cal enrollees.

The Independent Medical Review Process

Whom to contact:	California Department of Managed Health Care HMO Help Center
Who can appeal:	You, your provider (with consent), or your authorized representative
What you can appeal:	Your plan's decisions regarding experimental or investigational treatment and disputed medical necessity services.
When you can appeal:	You must request review within 6 months of your health plan's denial of care or grievance determination.
What to send:	Enrollees are not required to submit an application; an independent medical review can be requested over the phone.
What you must pay:	No charge
What will happen:	The California HMO Help Center will: 1) Refer qualifying applications to the Independent Medical Review Organization. The Independent Medical Review Organization will: 2) Notify you and your health plan that the case has been accepted. 3) Complete the review and make a determination in writing.
When you will get a decision:	Usually within 30 days
In urgent situations:	Call the DHMC Consumer Help Line for emergency or urgent situations.

How to Get More Information

California Department of Managed Health Care (DMHC) www.dmhc.ca.gov
California HMO Help Center's Consumer Help Line: 888-HMO-2219
TDD 877-688-8981
Fax 916-229-4326

State: 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:	1) Health plan notifies the insurance department by fax that you have requested an external review. 2) The insurance department assigns an independent external reviewer. 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. 4) The reviewer makes a decision and notifies you, your health plan, and the department of insurance.
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/

State: 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 authorized 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 all levels of the health plan's internal process, you must appeal within 30 days from receipt of the final denial letter from the health plan.
What to send:	• A completed "Request for External Appeal" form (available from the Insurance Dept) • Evidence of enrollment (such as a photocopy of your insurance card) • Copies of all pertinent correspondence • Copy of letter saying all internal appeals have been exhausted. • Copy of certificate of coverage • Filing fee
What you must pay:	$25 (the fee is waived under certain conditions)
What will happen:	1) The Insurance Department will assign the appeal to an external review agent. 2) The external review agent will conduct a preliminary review to determine if the request is eligible for full review. 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. 4) The Insurance Dept. will notify you, your doctor, the plan, and the review company.
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, 800-203-3447 (in-state only)
www.state.ct.us/cid/

State: Delaware

General Information

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.

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: 1. Your name & address 2. Your health plan information 3. A brief request for review by IHCAP (Independent Health Care Appeals Program) There is no limitation on supplying additional information to the IURO.
What you must pay:	No charge
What will happen:	1. Your health plan will notify the Department of Health and Social Services (DHSS) 2. DHSS will assign an Independent Utilization Review Organization (IURO). 3. The IURO will review the case and make its determination as appropriate. 4. The IURO will make a decision and notify you.
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, 800-942-7373 or 302-995-8521

State: 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:	1. Written request for appeal 2. Completed medical record consent form 3. Final decision of health plan
What you must pay:	No charge
What will happen:	The Director will: 1. Evaluate the appeal for processing (is the complainant a member, are the requested services covered benefits, is all information available etc.) 2. Notify you whether the appeal is eligible for processing 3. If acceptable, assign the appeal on a rotating basis to an independent review organization. The independent review organization will: 1. Conduct a full review by at least 2 physicians Either you or a health plan representative may request to appear in person at a hearing by the review organization
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.com
Grievance and Appeals Coordinator, 202-442-5979

State: 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 (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, non-authorization or denial of services you believe are covered by the plan, out of network requests.
When you can appeal:	Unless the grievance is urgent, you must file only 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:	1) You send the release form and supporting information. 2) The health plan submits pertinent information. 3) The SPSAP analyst determines whether the case is one over which the program has jurisdiction 4) The SPSAP analyst prepares the information for a hearing 5) A hearing is scheduled 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. 7) The SPSAP panel will evaluate the case and prepare a written recommendation within 15 days, unless more time is needed to gather necessary information requested by the panel. 8) You and your health plan have 10 days after receiving the recommendation to submit written objections. 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. 10) The health plan has 30 days to comply with the final determination.
When you will get a decision:	Within 165 days
In urgent situations:	An expedited review is available for cases in which there is a perceived 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

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

State: Georgia

General Information

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

The Independent Review Process

Whom to contact:	Georgia Department of Community Health, Division of Health Planning
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: 1. Name of person seeking treatment 2. Name of authorized person acting on patient's behalf 3. Address & phone number of enrollee 4. Name of health plan and policy number 5. Copy of the notice denying treatment from the health plan
What you must pay:	No charge
What will happen:	The Division of Health Planning will: 1) Notify you in writing that your request was received. 2) Determine if you are an eligible enrollee. 3) Randomly assign your case to an independent review organization and provide you with its name and address. 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). The independent review organization will: 1) Review your case. 2) Made a determination in writing.
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/

State: 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:	1) Your health plan will send any documents to the reviewer within 7 days of notification (within 48 hours for an expedited review). 2) The insurance commissioner will appoint a 3-member review panel. 3) For disputes involving less than $500, the insurance commissioner may conduct a review without appointing a review panel. 4) A review hearing will be conducted within 60 days of the original request 5) The review panel will decide whether your health plan acted reasonably by a majority vote. 6) The commissioner of insurance will issue an order affirming, modifying, or reversing the health plan's decision within 30 days of the hearing.
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 with 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/

State: Idaho

General Information

As of September 30, 2001, 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.

State: 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:	1) Your health plan will provide for selection of an external independent reviewer jointly by you, your provider, and the health plan. 2) Your health plan will provide all documentation to the reviewer. 3) The reviewer will make a decision within 5 days of receiving all information
When you will get a decision:	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.state.il.us/ins/ochibrochure.htm

State: Indiana

General Information

Health plan's 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 (with consent), or your authorized representative
What you can appeal:	Denials or limitations 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, 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:	1) The plan selects an independent review organization for your case on a rotating basis and sends pertinent information. 2) The reviewer may ask for additional information 3) The reviewer will notify you and your health plan of the decision.
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 800-622-4461 (in-state) or 317-232-2395
www.state.in.us/idoi

State: 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:	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. 2. A photocopy of the letter denying coverage from your health plan 3. The $25 filing fee
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

State: 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:	1) The Insurance Commissioner reviews the case within 10 days to determine if it qualifies for review. 2) If the case is accepted, it is sent to the external review organization. 3) You and your health plan have 7 days to provide additional information. 4) The case is assigned to a physician 5) The review organization notifies you, your health plan, and the Insurance Commissioner of the decision
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, 800-432-2484 (in state)
www.ksinsurance.org

State: 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 costing you at least $100.
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:	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. 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 you will receive an external review within 5 days. 3) If you are granted an external review, an independent review entity will be assigned to your case. 4) The independent review entity decides your case
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, 800-595-6053 or 800-462-2081 (Hearing Impaired)
www.doe.state.ky.us/

State: 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:	1) The MNRO will send all pertinent information to its designated independent review organization within 7 days of the request. 2) The review organization will evaluate the information and respond with a recommendation to you, the MNRO, and your provider.
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 800-259-5300 or 225-219-4770
www.ldi.state.gov

State: 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 your 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 info 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 800-300-5000 (in Maine)
www.maineinsurancereg.org

State: Maryland

General Information

Maryland requires health plans to establish an internal grievance process that provides a response within 30 days of filing for most situations, within 24 hours for emergencies, and within 45 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.

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.
When you can appeal:	After denial for coverage has been appealed through the health plan's internal process, you must file within 30 days from receipt of the final adverse determination, unless there is a compelling reason (as determined by the MIA)
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 medical records.
What you must pay:	No charge
What will happen:	1) The Insurance Commissioner will notify your health plan within 5 working days after receiving your request. 2) Your health plan will provide all pertinent information within 7 working days of notification. 3) The Commissioner may seek advice from an independent review organization. 4) The insurance department will investigate your case and return a final decision.
When you will get a decision:	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.
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 Insurance Administration.

How to Get More Information

Maryland Insurance Information, 800-492-6116 (800-735-2258 TTY)
www.mdinsurance.state.md.us

For help in filing appeals forms, call the Attorney General Health Education and Advocacy Unit 877-261-8807

State: Massachusetts

General Information

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.

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:	Denials for services considered not medically necessary
When you can appeal:	You must file within 45 days after receiving a final adverse determination.
What to send:	Follow the procedures provided by your health plan or request an external review application from the Department of Public Health.
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 significant negative change in your medical condition at issue. 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/index.htm

State: 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:	1) Completed OFIS Health Care Request for External Review form 2) Copy of the written final adverse determination from your health plan. 3) Any additional supporting information
What you must pay:	No charge
What will happen:	1. OFIS reviews your request and check that the denied service is covered. 2. If the grievance involves non-medical issues, it will be reviewed by OFIS staff. 3. If the grievance involves medical issues, the request is assigned to an Independent Review Organization (IRO). 4. The Independent Review Organization reviews medical information and the denial and makes a recommendation within 14 calendar days. 5. OFIS reviews the recommendation of the Independent Review Organization.
When you will get a decision:	The review process takes approximately 26 days to complete: 1. OFIS will review your request within 5 business days. 2. The IRO has 14 calendar days to evaluate your case and make a recommendation. 3. OFIS will contact you regarding the final decision within 7 business days of receiving the IRO recommendation.
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.

How to Get More Information

Michigan Office of Financial and Insurance Services (OFIS) 877-999-6442
www.cis.state.mi.us/ofis

State: 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:	1) A completed Request for External Review, which includes a medical records release. 2) $25 check. 3) Any supporting information for your case.
What you must pay:	$25 (may be waived in cases of hardship)
What will happen:	1) The Department of Health will evaluate your case for eligibility. 2) Your case will be sent to an independent review organization a) If your case does not involve a medical determination, you may request mediation, which involves a hearing by telephone or in person. b) If no agreement is reached, your case will be returned to the review organization. 3) You, your provider, and your health plan will be notified within 3 days after the review organization receives the case. 4) You, your provider and your health plan may submit pertinent information to the review organization within 10 days after notification. 5) The review organization will evaluate your case and make a decision.
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 800-657-3916
www.health.state.mn.us/divs/hpsc/mcs/extreview.htm

State: Mississippi

General Information

As of September 30, 2001, 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.

State: 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:	1) MDI checks that your request is appropriate for independent review. 2) MDI request you and your health plan to submit all relevant and pertinent information within 20 days (although you may take longer if necessary). 3) MDI sends the entire request to the independent review organization. 4) The review organization notifies the Director of MDI of its decision. 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.
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 800-726-7390
www.insurance.state.mo.us

State: Montana

General Information

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 must file after denial for coverage has been appealed through all levels of the health plan's internal process (unless that process is not completed within 60 days of receipt of the request for appeal). 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 406-444-0156

State: Nebraska

General Information

As of September 30, 2001, 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.

State: Nevada

General Information

As of September 30, 2001, 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.

State: 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:	1. Competed external appeal request form 2. Copy of letter denying service at final level 3. Evidence of insurance (e.g. photocopy of insurance card 4. Copy of certificate of coverage or policy benefit booklet 5. Any medical records or other information you want the reviewer to consider
What you must pay:	No charge
What will happen:	1. Preliminary review by the Insurance Department within 7 days of receipt to determine if the request is complete and eligible for review. 2. If the request is not complete, you have 10 days to supply the information needed. 3. If the request is complete, the Insurance Department selects an independent review organization and notifies you and the health plan. 4. After the appeal is accepted, the insurer must provide all relevant information to you and the review organization within 10 days. 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. 6. The record of the case will be closed and no new information may be provided after the second 10-day window.
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 800-852-3416
www.state.nh.us/insurance/

State: 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: 1. Name and address of the health plan 2. Brief description of the pertinent medical condition 3. Copies of the Informal and Formal Internal Appeal denials 4. Written medical records release 5. Copy of your summary of insurance coverage
What you must pay:	$25 (may be reduced or waived in cases of financial hardship)
What will happen:	1. The Department will refer your appeal to an independent utilization review organization. 2. The review organization will evaluate your appeal to determine if it is acceptable. 3. If your appeal is accepted for further review, you will receive a decision within 30 days after all information needed for review has been received.
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

State: New Mexico

General Information

New Mexico provides for an internal review, which consist 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, your provider (with consent), or your representative 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:	1. The Division of Insurance will complete the external review within 30 working days or 72 hours for expedited reviews. 2. If the case is not accepted for an external review hearing the Superintendent will notify the enrollee. 3. If the case is accepted, the Superintendent scheduled the external hearing immediately. 4. A panel of independent hearing officers will hear the case. The panel will consist of two physicians and one attorney. 5. The panel will make a recommendation to the enrollee, health plan, and Superintendent after the hearing. 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. 7. The order is binding on the health plan and the grievant. 8. Both the grievant and the health plan may take the case to district court.
When you will get a decision:	30 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

State: 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 external appeal.

The External Appeal Process

Whom to contact:	New York State Insurance Department
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 the first level of the health plan's internal process or the plan and patient jointly agree to waive the internal appeal, you must file within 45 days from receipt of the first level adverse determination or letter from health plan waiving the internal appeal.
What to send:	Completed application (a physicians 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:	1. The insurance department will:Review the appeal request within 5 business days. 2. Assign the request to an external review agent if the request is eligible and complete. 1. The external review agent will: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 800-400-8882
www.ins.state.ny.us

State: North Carolina

General Information

As of September 30, 2001, North Carolina did not have an external review program for denials of coverage for services that health plans consider either experimental or not medically necessary. North Carolina does require health plans to have an internal program that is similar to external review.

How to Get More Information

Contact your health plan.
North Carolina Department of Insurance, www.ncdoi.com
Consumer Services Division, 800-546-5664

State: North Dakota

General Information

As of September 30, 2001, 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.

State: Ohio

General Information

Ohio requires health plans 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.

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:	1) A written request for standard reviews, or a phone call or fax followed up by written confirmation for expedited reviews. 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)
What you must pay:	No charge
What will happen:	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. 1) The Superintendent will randomly assign two independent review organizations to your case 2) Your health plan will choose one of the independent review organizations. 3) The review organization will evaluate the information submitted and make a decision based on safety, efficacy, appropriateness, and cost effectiveness. For appeal of denial based on question of contract coverage, you need to contact the Superintendent. 1) The Superintendent will determine if your service is covered and notify your health plan. If the case involves medical issues, the Superintendent will notify your health plan to either cover the service or provide an external review.

When you will get a decision:	The Independent Review Organization has 30 days to complete the review for a standard review and seven 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 800-686-1526
www.ohioinsurance.gov

State: 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.
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:	1) Your health plan will select an independent review organization. 2) The Department of Health will tell you which review organization was selected. 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. 4) Within 5 days of final reviewer selection, you must provide: a. A written request for external review including the reasons why you are requesting the review, b. a copy of the decision to deny coverage from your health plan c. a medical records release. 5) After receiving your information, the review organization will conduct a preliminary review to determine if your case is eligible for external review. 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. 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. 8) The review organization will decide your case.
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

State: Oregon

General Information

Oregon recently passed legislation that will establish external review as of July 1, 2002.

The Independent Review Process

Whom to contact:	Yet to be determined
Who can appeal:	Yet to be determined
What you can appeal:	Yet to be determined
When you can appeal:	Yet to be determined
What to send:	Yet to be determined
What you must pay:	Yet to be determined
What will happen:	Yet to be determined
When you will get a decision:	Yet to be determined
In urgent situations:	Yet to be determined

How to Get More Information

Oregon Department of Consumer & Business Services Insurance Division, 503-947-7980
http://www.cbs.state.or.us/external/ins/

State: Pennsylvania

General Information

Pennsylvania distinguishes between complaints and grievances 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 complaint or a grievance. 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. If grievances are not satisfactorily resolved in their two-step process, they can be appealed for review by an independent utilization review organization.

As of June 9, 2001, new Department of Health Managed Care Program Regulations became effective.

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

State: 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 (with consent), 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 2nd level of the health plan's internal process, you must file within 60 days from receipt of the 2nd 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:	1. You will select the external review agency. 2. The review agent will provide information to the external appeals agency within 5 days of receiving the initial notification of appeal. 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.
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

State: South Carolina

General Information

South Carolina's regulations for external review were not final as of 8/3/01.

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, 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:	Within 5 business days of receiving your request for external review, your health plan will either: i. Assign your case to an independent review organization and send documentation to the review organization, or ii. Notify you in writing why your request does not meet the requirements for external review. If your health plan does not send the documentation, the review organization may terminate the review and reverse the adverse determination. 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 may also submit additional information and documentation to support your case within 7 business days after receiving this notification. 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.
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 800-768-3467 or 803-737-6180
www.state.sc.us/doi

State: South Dakota

General Information

As of September 30, 2001, 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.

State: 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:	1) Your health plan has 5 days to provide all pertinent information to the independent review entity. 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. 3) The independent review entity will review your case and make a decision.
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

State: Texas

General Information

Texas requires health plans and Utilization Review Agents (URAs) 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 appeal 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, your provider is entitled to appeal the denial of the claim to the health plan.
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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 determines are not medically necessary or appropriate.
When you can appeal:	After denial for coverage has been appealed through the health plan'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 is supposed to provide you with this form at the time it denies services and again if your appeal is denied).
What you must pay:	No charge
What will happen:	1. The health plan will immediately notify the Department of Insurance that you have requested an independent review. 2. The Department will randomly assign your case to an independent review organization within one business day of notification. 3. The Department will notify everyone involved about the assignment. 4. The health plan will send all pertinent information to the review organization by the 3rd day after receiving your review request. 5. The review organization will make a determination.
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 800-252-3439 (463-6515 in Austin)
www.tdi.state.tx.us

State: Utah

General Information

The external review process in Utah was effective as of January 1, 2001, but regulations, including minimum standards for internal review and time-frames for completing the external independent review, were still being deliberated as of 8/1/01 because of changes in November 2000 to federal regulations for ERISA plans.

The Independent Review Process

Whom to contact:	Yet to be determined
Who can appeal:	Yet to be determined
What you can appeal:	Yet to be determined
When you can appeal:	Yet to be determined
What to send:	Yet to be determined
What you must pay:	Yet to be determined
What will happen:	Yet to be determined
When you will get a decision:	Yet to be determined
In urgent situations:	Yet to be determined

How to Get More Information

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

State: 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: 1) for covered services the health plan determines are not medically necessary, 2) limitations on selection of providers that are inconsistent with laws, regulations, or plan limits, 3) determined to be experimental or investigational, or an off-label use of a drug, 4) medically-based determination of a pre-existing condition.
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:	1) A completed request for appeal form. 2) The filing fee (check or money order) or request for waiver or reduction of fee.
What you must pay:	$25 (the fee is waived under certain conditions).

What will happen:	1. The Division will evaluate the request and determine whether or not it qualifies for external review within 5 days. 2. The Division will contact you regarding whether or not your request is accepted for review. 3. If your request is accepted for review, the Division will ask you and your health plan to send 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. 4. 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. 5. After the documentation and responses have been received, the Division will assign your case on a rotating basis to an independent review organization. 6. All information submitted will be sent to the review organization. 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.
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

State: 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:	1. The BOI will review your appeal to verify eligibility. 2. The BOI will select an independent healthcare review organization. 3. You, your physician, and the health plan will be asked to provide pertinent information within 20 working days. 4. The review organization will recommend a decision. 5. The Commissioner of Insurance will review the recommendation to assure that it is not arbitrary or capricious.
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 800-552-7945 (in Virginia only), 804-371-9206 TDD
www.state.va.us/scc/division/boi

State: 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 to 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:	Not specified
Who can appeal:	You
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 you 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:	Not specified
What you must pay:	No charge
What will happen:	1. The insurance commissioner will select a certified independent review organization. 2. Your health plan will provide the pertinent documentation to the review organization with 3 business days of receiving your request for review. 3. The review organization will make a decision
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 800-562-6900
www.insurance.wa.gov

State: West Virginia

General Information

West Virginia passed the Patients' Bill of Rights in April 2001. External reviews will become 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; it is not yet determined if any plans will receive this exemption.

The External Review Process

Whom to contact:	Yet to be determined
Who can appeal:	Yet to be determined
What you can appeal:	Yet to be determined
When you can appeal:	Yet to be determined
What to send:	Yet to be determined
What you must pay:	Yet to be determined
What will happen:	Yet to be determined
When you will get a decision:	Yet to be determined
In urgent situations:	Yet to be determined

How to Get More Information

Contact your health plan.

State: Wisconsin

General Information

Wisconsin's independent review law was passed in early 2000 and as of January 1, 2001 no rules had been finalized and the independent review process was not yet operational (expected by fall 2001). 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 all levels of 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:	1) Written request 2) The name of the review organization you want to review your case.
What you must pay:	$25 (if the review organization rules in you favor, even in part, your payment will be refunded)
What will happen:	1) Your health plan must submit all pertinent documents to the independent review organization within 5 business days of receiving your request. 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. 3) Your health plan will send any additional information within 5 days of receiving the request for additional information. 4) You or your health plan may also submit additional medical or scientific evidence to each other and the review organization.
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

800-236-8517 (in Wisconsin)
badger.state.wi.us/agencies/oci/oci_home.htm

State: Wyoming

General Information

As of September 30, 2001, 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.