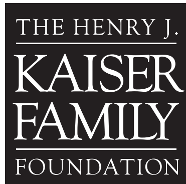

Consumers Union

A CONSUMER GUIDE TO HANDLING DISPUTES WITH YOUR EMPLOYER OR PRIVATE HEALTH PLAN, 2003 UPDATE

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INTRODUCTION

Most people now get their health care through some form of managed care plan – a health maintenance organization (HMO), preferred provider organization (PPO), or point-of-service option (POS). And most of the time, these people receive the care they need. But when a health plan decides that the care you or your doctor wants is not medically necessary, or limits your care in some way, or denies payment for your care, the potential for a dispute with your plan arises. The health plan may be justified in refusing to provide or pay for treatment if it is generally not considered medically necessary, or not necessary in your situation, or not covered by your policy. The cases most likely to end up in dispute are often not clear-cut, such as treatments that may be new and experimental, whose value is unproven.

The states and the federal government determine how health plans deal with enrollee complaints and appeals. States have enacted rules that plans must follow for handling enrollee complaints and appeals inside the health plan. These reviews conducted by the plan are known as "internal review." The federal government also has requirements that employer-sponsored health plans must follow for processing claims and internal review of appeals. In recent years most states have gone further, setting up procedures for "external review," or the reconsideration of a health plan's denial by an organization 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. The review is typically made by a person or panel of individuals who are not part of the health plan. As of August 2002, 41 states plus the District of Columbia have legislated such external review procedures.[1]

[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.

Consumers have certain rights under state and federal laws that they can exercise if they disagree with a decision their plan makes about medical coverage. These rights apply to both the "internal" review process and "external review." The rights that you have depend on the type of health plan you have and which state you live in.

This Guide will help you navigate your plan's internal appeals procedure, as well as your state's external review process. The term "health plan" is used in this Guide to broadly refer to many types of employer or private insurance coverage, including coverage provided by insurance companies, Blue Cross/Blue Shield plans, health maintenance organizations (HMOs), preferred provider organizations (PPOs), and point of service plans (POSs). Note that in some states the laws apply to all of these various types of insurance coverage, while in others the laws may be limited to managed care plans such as HMOs. You cannot use this Guide for resolving disputes if you have Medicare or Medicaid coverage.

Section 1 of this Guide, "Know Your Coverage," is important to read before you have a dispute. Many disputes arise because people don't know what is or is not covered by their health plan, and you can avoid a lot of hassle by knowing what is allowed. There may be referral or payment rules that you need to follow. At the end of Section 1, we present some questions to help you diagnose your coverage and dig into the important details.

Section 2, "Appealing Through Your Plan," discusses how to appeal inside your health plan a decision that you disagree with. The internal appeal is an important step for consumers to understand because many disputes are resolved during this process, and because most state laws require you to complete the internal appeal process before appealing outside of the health plan. 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, and the federal government requires employer-sponsored plans to follow certain rules for internal review.

Section 3, “Getting an Independent Opinion -- External Review in Your State” explains what to expect if you use your state’s external review process.

Section 4, “State-by-State External Review Programs,” provides a summary of the important aspects of each state’s procedures and who to contact for further information.

SECTION 1 -- KNOW YOUR COVERAGE

The best way to avoid the aggravation and anxiety that often accompanies a dispute with your health plan is to know your coverage and follow the health plan's procedures for referrals and approvals. Many disagreements between patients and their health plans occur because patients do not have a clear understanding about how their health plan 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.

Understand What Services Are Covered

If your employer provides health care coverage, you probably received a Summary Plan Description when you first signed up. It will discuss covered services, limits on benefits, and your payment amounts 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. Managed care plans exclude many types of services that are not covered under your insurance policy. 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, or you can discuss exclusions with your human resources manager at work.

Understand Your Plan's Rules

Knowing your plan's rules about such things as referral procedures and payments for out-of-network services will help prevent problems that may lead to claims disputes later on.

Referral Rules

Many health plans require patients to get a referral from their primary care doctor before going to a specialist or before receiving certain services. The primary care doctor acts as a "gatekeeper" to oversee and coordinate your care. 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 you get it. 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. 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 approval has not been granted or 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.

Rules That Determine Your Payment

If you have a health plan such as a POS or PPO 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 or more) 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) have the necessary information ready in a convenient place when you need to arrange care.[2]

My insurance coverage is through:

- [ ] My employer -- check if:
  - [ ] my plan is an insured plan (subject to state insurance laws)
  - [ ] my plan is a self-funded plan (NOT subject to state insurance laws)
- [ ] An individually purchased policy
- [ ] A group affiliation policy (such as through a civic or educational organization)
- [ ] Other: ________________________________

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: ____

[2] The external review procedure described later in this Guide will not usually apply to your plan if it is a self-insured plan governed by ERISA (See Section 1).

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 section in my Evidence of Coverage. My insurance will not pay for, or limits, the following services:

[ ] ____
[ ] ____
[ ] ____
[ ] ____
[ ] ____
[ ] ____

My plan will cover services at 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.

Understand What Type of Coverage You Have

If a dispute does arise with your health plan, you need to understand what type of health plan you have in order to know what rights you have.

Employer-Sponsored Coverage

Most people with private insurance are covered by an employer-sponsored health plan. An employer-sponsored health plan is one that you or a family member enrolls in through work and to which the employer makes a contribution for the cost of coverage. If you are enrolled in this type of health plan, you have a right under federal regulations to appeal disagreements about benefits through the plan's internal appeals process. Whether you have additional rights under state law will depend on whether the health plan is insured or self-funded. This is because a federal law, called the Employee Retirement Income Security Act, or ERISA, prevents states from applying their external review laws to employer-sponsored health plans that are self-funded. A health plan is "self-funded" if the employer pays for the costs of health care directly rather than purchasing insurance for its employees.

It can be a challenge for consumers to find out if their health plan is insured or self-funded. You may think your coverage is from a health insurance company like CIGNA or Aetna, but if you work for a large employer, those insurance companies may not actually be insuring you. Instead, they may simply process the claims as a "third-party administrator" for your employer's self-funded plan. To find out whether your employer-sponsored plan is self-funded, first ask the person who administers the benefits where you work. You also can look in the Summary Plan Description that you received from your employer when you enrolled, but often the language is ambiguous on this issue. If you can't find out from your employer or the Summary Plan Description, you can contact the U.S. Department of Labor's regional office nearest to you.

If you are enrolled in an employer-sponsored health plan that is insured, you usually have rights under federal and state laws if you have a dispute with your health plan. Although ERISA also prevents some state laws from applying to insured employer-sponsored health plans, a recent U.S. Supreme Court case found that a state could apply its external review law to a claim dispute involving an insured employer-sponsored health plan. Although this area of law remains somewhat unsettled, consumers should assume that your state's laws apply unless a court says that they do not. Section 4 of this Guide will tell you if your state has enacted an external review law and how it works.

If you are enrolled in an employer-sponsored health plan that is self-funded, state laws that provide for internal or external review of health plan disputes will not apply to your plan. However, your health plan must follow a recent federal regulation effective January 1, 2003 for internal plan claims procedure and review of disputed claims (described later).

Individually Purchased Coverage

If you purchased insurance directly from a health plan (your employer does not provide coverage or contribute to its cost), you need to look at the laws of your state to determine if you have the right to appeal a dispute over benefits using the plan's internal procedures or your state's external review organization. Most states have laws that provide for internal and external review of disputes over coverage you purchase as an individual.

SECTION 2 -- APPEALING THROUGH YOUR PLAN

Disputes with health plans arise over whether services are covered, which 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 appeals process to handle these disagreements. A recent federal regulation effective January 1, 2003 establishes procedures and timelines for claims disputes between consumers and employer-sponsored health plans (both insured and self-funded). Most states have their own rules about how a health plan's internal appeal procedure must be structured. Even if you are eligible to use your state's external grievance procedure, you will usually have to finish your health plan's internal appeal process first, so it is important to learn how your plan's internal process works.

Health plans may have different appeals processes for different types of disputes, depending on the nature of the disagreement. For example, a health plan may have a different process for resolving a complaint about appointment times than for a complaint involving a denial of a benefit or a refusal to authorize a medical procedure. Health plans may also have expedited processes to deal with requests for medical services that your doctor feels are urgent. The federal regulation requires employer-sponsored health plans to handle appeals for urgent care claims as soon as possible, but definitely within 72 hours. You need to tell your health plan how urgent your situation is when you first communicate with your plan. The federal regulation also sets up other requirements for employer-sponsored health plan appeals, such as allowing you to submit comments or other evidence to support your case, and requiring health plans to provide you access to the documents used to determine whether or not you have coverage for the services in dispute. Health plans cannot require more than two levels of review for denied claims, cannot charge a fee for the review, and must allow participants 180 days to file an appeal.

Preparing an Informal Appeal

When you have a disagreement with your health plan, your first step is to contact the plan's 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 a reply. Mark that date 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 Appeal

If your attempts to deal with the health plan informally are not successful, you will have to file a formal appeal. Health plan procedures vary, but all will require details submitted in writing. Some plans allow you to initiate the appeal 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 an appeal form, consult your Summary Plan Description or the Evidence of Coverage for a description of the appeal process. 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 want to have covered
- Information supporting why the service should be covered
- 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 appeal within one year of the date of treatment or within 60 days of the date the plan tells you it is denying your claim, whichever comes first. Employer-sponsored health plans must allow you at least 180 days to file an appeal.

Health Plan 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 appeal 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. Note that the federal regulation applicable to employer-sponsored health plans provides consumers with the right to present written comments, documents, records, and other evidence to the health plan for consideration in the appeal process.

Response times vary from plan to plan depending on the type of complaint. The plan will usually act more quickly if the service has not been provided, or if the patient is already in the hospital, than if the service has already been given. Some health plans, for example, say that they handle the first level of reviews within one business day for services not yet provided, but others may take longer. Billing and administrative disputes may be handled differently from those involving payment for services. Note that the federal regulation applicable to employer-sponsored health plans sets maximum response times for different types of appeals: 30 days if the service has not yet been provided, 60 days if it has been provided. State law also may establish response times for appeals. If your appeal involves an urgent need for care, make that clear to the health plan so the health plan can expedite your 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 review panel. It may include physicians, consumers, or sometimes representatives of the health plan.

If your plan is subject to state external review requirements, the health plan will usually notify you that it has denied your appeal and give 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 response times for each level of review)
1st level ____
2nd level ____

Note: the federal regulation applicable to employer-sponsored health plans provides that a health plan cannot require more than two levels of appeals, and that if two levels are used, both must be completed within the response times permitted by the regulation.

Arbitration

Your employer-sponsored health plan may require that you enter into mandatory non-binding arbitration as part of the internal review process. Arbitration is a process in which a dispute is resolved by impartial individuals. The arbitration must follow the same federal rules that apply to any internal appeal. In addition, you are allowed to challenge the arbitrator's decision, and may take your dispute to court.

In addition, your employer-sponsored plan may offer voluntary arbitration after one or two levels of internal review. Submitting your dispute to arbitration is optional, and federal law requires that your decision to use or not use this alternative does not affect your rights to any other benefits. If you decide not to use voluntary arbitration, your health plan cannot use this against you in subsequent appeals.

SECTION 3 -- GETTING AN INDEPENDENT OPINION -- EXTERNAL REVIEW IN YOUR STATE

Most states have external review programs, but the details of administering these programs 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 variations found in states' external review programs. Consult the state-by-state tables in Section 4 of this Guide to learn specific requirements for your state and who to contact for further information.

Who Can Appeal

In most states, state external review requirements apply to all types of health plans. In other states, they apply only to managed care plans (such as HMOs, PPOs, or POS plans), or just to HMOs.

If you are covered by an employer-sponsored plan, you typically can use your state's external review program if your health plan is an insured employer-sponsored plan or a private plan that you have purchased on your own. As we have noted, state external review laws do not apply to employer-sponsored health plans that are self-insured, so if you are in a self-insured or other plan exempted by ERISA from state law, you cannot use your state's external review procedure. At this time, your only recourse is to sue in court. State external review programs also do not apply to Medicare and Medicaid beneficiaries. If you are a Medicare beneficiary, you must follow the Medicare external review process described in your Medicare Handbook. If you are a Medicaid beneficiary, you have the right to a Fair Hearing. Your state or local Medicaid Office can tell you more about the procedure.

In most states, you can give someone else written authorization to appeal for you. In many of the states, your provider may appeal on your behalf with your written authorization.

What Types of Problems You Can Appeal

Most 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. 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 will not 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 over coverage issues such as experimental treatments. Other states allow denials of coverage for treatments your health plan says are experimental or investigational may be submitted for external review. And a few states do not clearly address the issue and may or may not accept your request for external review. Check the descriptions of state regulations in Section 4 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 may have to proceed with treatment before knowing if the plan will pay for it. In many states, you will be able to submit your dispute for external review even if the services have been provided; in others you may submit your case only if services have not been provided.

Most states require you to complete all of the steps in your plan's internal appeals 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 to file for external review at the same time you appeal to the health plan if your case is 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 what is called 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 or selected by the plan. Usually you do not have to pay 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 made by external review, or whether you can appeal through the court system.

SECTION 4 -- STATE-BY-STATE EXTERNAL REVIEW PROGRAMS

This section provides tables with information about the external appeal processes available in each state. Where pertinent, information about the internal appeal process is also provided. Follow the procedures for your state, which were current as of August 2002. For more information, call the state agency 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 or with the Department of Labor about filing an appeal if your plan is a self-insured employer-sponsored plan.

Alabama

General Information:

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

How to Get More Information:

Contact your health plan.
Alabama Department of Public Health, 334-206-5300

Alaska

General Information:

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

The External Appeal Process:

Whom to contact:	Your health plan
Who can appeal:	You or your health plan
What you can appeal:	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 standards and guidelines used to make the decision, 2. Pertinent personal health or medical information, 3. Your provider's opinion, 4. The group health insurance plan. The external appeal agency may also consider: 1. Reliable and valid studies, 2. Government conducted or financed professional conference results, 3. Government treatment and practice guidelines, 4. Government coverage and treatment policies, 5. Generally accepted principals of medical practice, 6. Expert opinions, 7. Peer reviews, 8. Community standard of care, 9. Anomalous utilization patterns.
What you must pay:	Charges incurred by you or your physician in support of the external appeal.
What will happen:	The External Appeal Agency will make a decision and supply the decision in writing to you and your health plan as soon as possible.
When you will get a decision:	No later than 21 working days after the appeal is filed.
In urgent situations:	An expedited review will be completed within 72 hours after the request for an external appeal.

How to Get More Information:

Contact your health plan.

Arizona

General Information:

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

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

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

Whom to contact:	Your health plan
Who can appeal:	You, your provider, or your authorized representative
What you can appeal:	Denied claims or denied requests for services
When you can appeal:	You must appeal within 30 days after receiving notification of denied formal appeal or within 5 days after an expedited appeal denial.
What to send:	Either write a letter or use the request form provided in your health plan's information packet. You are not required to use the form.
What you must pay:	No charge
What will happen:	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 coverage issues: within 20 business days from the date your request is received. For standard reviews based on medical necessity: approximately 36 days from the date your request is received.
In urgent situations:	To be eligible for the three-tiered expedited appeal process, your treating provider must submit a written certification to your insurer and send supporting documentation indicating that waiting through the standard appeal process is likely to cause a significant negative change in your medical condition at issue. After you have completed 2 internal expedited levels of review, you may request expedited external review, which will be completed within 3 business days (for coverage issues) or 9 business days (for medical necessity issues).

How to Get More Information:
Statewide: 1-800-325-2548
www.state.az.us/id

Arkansas

General Information:

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

How to Get More Information:

Contact your health plan.

California

General Information:

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

The Complaint Resolution and Independent Medical Review Process:

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

How to Get More Information:

California Department of Managed Health Care, www.hmohelp.ca.gov
California HMO Help Center: 1-888-HMO-2219
TDD 877-688-8981
Fax 916-229-4326

Colorado

General Information:

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

The Independent External Review Process:

Whom to contact:	Your health plan
Who can appeal:	You, your provider (with consent), or your authorized representative
What you can appeal:	Denials of coverage for services the health plan determines are not medically necessary or are experimental.
When you can appeal:	After denial for coverage has been appealed through all levels of the health plan's internal process, you must appeal within 60 days from receipt of the final adverse determination.
What to send:	A completed request form
What you must pay:	No charge
What will happen:	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

Connecticut

General Information:

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

The External Appeal Process:

Whom to contact:	Connecticut Insurance Department
Who can appeal:	You, your provider (with consent), or your legal representative
What you can appeal:	Denials of coverage for services covered in your contract that your health plan determines are not medically necessary
When you can appeal:	After denial for coverage has been appealed through 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 uti 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, 1-800-203-3447 (in-state only)
www.state.ct.us/cid

Delaware

General Information:

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

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

The Independent Health Care Appeals Process:

Whom to contact:	Your health plan
Who can appeal:	You or your authorized representative
What you can appeal:	Denial, reduction, or termination of health care benefits that deprive the covered person of medically necessary covered services.
When you can appeal:	You must file within 60 days after you receive notice of an adverse determination from your health plan.
What to send:	A written request: 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, 1-800-942-7373 or 302-995-8521

District of Columbia

General Information:

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

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

The Formal External Review Process:

Whom to contact:	Director of the District of Columbia Department of Health
Who can appeal:	You, your provider (with consent), or your authorized representative
What you can appeal:	Denial, reduction, limitation, termination, or other delay of covered health care services.
When you can appeal:	After denial for coverage has been appealed through the health plan's formal internal process, you must file within 30 days from receipt of the written decision of the health plan. If the health plan fails to meet the deadlines for completing a formal internal appeal, the member may begin the external process without waiting for the health plan's decision.
What to send:	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.dc.gov
Grievance and Appeals Coordinator, 202-442-5979

Florida

General Information:

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

The External Appeal Process:

Who to contact:	Statewide Provider and Subscriber Assistance Program (SPSAP)
Who can appeal:	You, your provider (on your behalf), or your authorized representative
What you can appeal:	Denials of coverage for services the health plan determines are not medically necessary or are experimental or investigational, non-authorization or denial of services you believe are covered by the plan, out of network requests.
When you can appeal:	You must file <u>only</u> after completing all levels of the health plan's internal grievance procedure. You must file within 365 days of receiving the notice of final denial.
What to send:	A completed "Request for Review and Release Form"
What you must pay:	No charge
What will happen:	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 working 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 if the final order is in your favor.
When you will get a decision:	Within 165 days
In urgent situations:	An expedited review is available for cases in which there is a serious threat to continued health. An expedited review is scheduled for hearing within 45 days and resolved within 65 days. If there is an impending threat of death, an emergency case is heard within 24 hours.

How to Get More Information:

For quality of care: Agency for Health Care Administration, 1-888-419-3456
www.fdhc.state.fl.us/MCHQ/Consumer/SPSAP/index.shtml
For billing or enrollment problems: Insurance Consumer Helpline, 1-800-342-2762

Georgia

General Information:

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

The Independent Review Process:

Whom to contact:	Office of General Counsel, Department of Community Health
Who can appeal:	You or your authorized representative
What you can appeal:	Health plan denials of treatment for services that cost more than $500 and either appear to be covered services or are experimental treatments for patients with terminal conditions.
When you can appeal:	You must file after you have received a notice of adverse outcome from your health plan.
What to send:	A completed form or written request stating: 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 Office of General Counsel 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/

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 within 48 hours and the review must be completed within 72 hours.

How to Get More Information:

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

Idaho

General Information:

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

How to Get More Information:

Contact your health plan.

Illinois

General Information:

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

The External Independent Review Process:

Whom to contact:	Your health plan
Who can appeal:	You, your provider (with consent), or your authorized representative
What you can appeal:	Denials or limitations of coverage for health care services your health plan considers are not medically appropriate.
When you can appeal:	After completing all levels of your health plan's internal appeal procedure, you must file within 30 days of receiving written notice of an adverse determination.
What to send:	A written request, including necessary information or documentation to support your request.
What you must pay:	No charge
What will happen:	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:	In general, 35 days after your health plan receives the request for external review.
In urgent situations:	An expedited review is available if denial of the service could significantly increase the risk to your health; a decision will be made within 24 hours of receiving all necessary information.

How to Get More Information

Illinois Office of Consumer Health Insurance, 877-527-9431
www.ins.state.il.us/OCHI/Office_Consumer_Health_Ins.htm

Indiana

General Information:

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

The External Review Process:

Whom to contact:	Your health plan
Who can appeal:	You, your provider, or your authorized representative
What you can appeal:	Denials or limitations of coverage for services the health plan determines are not appropriate, medically necessary, or are experimental or investigational.
When you can appeal:	After denial for coverage has been appealed through all levels of the health plan's internal process, you must file within 45 days from receipt of the final adverse determination.
What to send:	A written request for external review
What you must pay:	The health plan may charge you up to $25 towards the cost of the review.
What will happen:	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, 1-800-622-4461 (in-state) or 317-232-2395
www.state.in.us/idoi

Iowa

General Information:

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

The External Review Process:

Whom to contact:	Iowa Insurance Division
Who can appeal:	You or your provider (with consent)
What you can appeal:	Denials for medical service claims your health plan believes are not medically necessary.
When you can appeal:	After denial for coverage has been appealed through all levels of the health plan's internal process, you must file within 60 days of the denial.
What to send:	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

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, 1-800-432-2484 (in state)
www.ksinsurance.org

Kentucky

General Information:

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

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

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

The External Review of Adverse Determination Process:

Whom to contact:	Your health plan
Who can appeal:	You, your provider (with consent and authorization), or your authorized representative
What you can appeal:	Adverse determinations: services, treatments, drugs, or devices that the health plan claims are not medically necessary or appropriate, or are experimental or investigational, for services that would have cost you at least $100 if you had no insurance.
When you can appeal:	After you exhaust the health plan's internal appeal process, or if you and your health plan agree to waive the internal appeal process, you must file within 60 days after receipt of an adverse determination.
What to send:	Written request, medical records release, and written designation/authorization of person or provider, if applicable.
What you must pay:	$25 filing fee payable to the independent review entity (may be refunded if the decision is in your favor, or may be waived for financial hardship).
What will happen:	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 not 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, 1-800-595-6053 or 800-462-2081 (Hearing Impaired)

Louisiana

General Information:

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

The External Review Process:

Whom to contact:	The Medical Necessity Review Organization (MNRO)
Who can appeal:	You, your provider (with consent), or your authorized representative
What you can appeal:	Denials of coverage for services the health plan determines are not medically necessary.
When you can appeal:	After denial for coverage has been appealed through all the levels of the health plan's internal process, you must file within 60 days from receipt of the second level appeal adverse determination.
What to send:	File a request with the MNRO
What you must pay:	No charge
What will happen:	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, 1-800-259-5300 or 225-219-4770

Maine

General Information:

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

The Independent External Review Process:

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

How to Get More Information:

Maine Bureau of Insurance, 1-800-300-5000 (in Maine)
www.maineinsurancereg.org

Maryland

General Information:

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

The Appeal Process:

Whom to contact:	Maryland Insurance Administration (MIA)
Who can appeal:	You, your provider (with consent), or your health plan
What you can appeal:	Denials of coverage for services the health plan determines are not medically necessary or are experimental or investigational. There is also a separate appeals process for coverage decisions.
When you can appeal:	After denial for medical necessity has been appealed through the health plan's internal process, you must file within 30 working days from receipt of the final adverse determination. If there is a compelling reason as determined by the MIA, you may go directly to the MIA. After denial of a coverage decision has been appealed through the health plan's internal process, you must file within 60 working days from receipt of the final appeal decision, except for an urgent medical condition.
What to send:	A written appeals and grievances complaint, including copies of all relevant documentation, such as the denial letter from the health plan and pertinent medical records.
What you must pay:	No charge
What will happen:	For a medical necessity appeal: 1. The MIA 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 MIA may seek advice from an independent review organization. 4. The MIA will investigate your case and return a final decision.
When you will get a decision:	For medical necessity: Within 30 working days of filing a complaint with the MIA if the service has not been provided; within 45 working days if the service has already been provided. The deadline may be extended up to an additional 30 working days if the pertinent information has not been received or it is necessary. For coverage decisions: The time requirement for investigation may vary.
In urgent situations:	For expedited reviews you will receive a response within 24 hours. If your appeal "involves compelling circumstances" you may skip the health plan's internal process and file directly with the MIA.

How to Get More Information:

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

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

Massachusetts

General Information:

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

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

The External Review Process:

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

How to Get More Information:

Office of Patient Protection, 1-800-436-7757 or fax 617-624-5046
www.state.ma.us/dph/opp/

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 checks 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. In most cases, 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. **The urgency of the condition must be substantiated in writing by a licensed physician.**

How to Get More Information:

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

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, 1-800-657-3916
www.health.state.mn.us/divs/hpsc/mcs/extrevufaq.htm

Mississippi

General Information:

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

How to Get More Information:

Contact your health plan.

Missouri

General Information:

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

The Independent Review Process:

Whom to contact:	Missouri Department of Insurance (MDI), Division of Consumer Affairs
Who can appeal:	You or your health plan
What you can appeal:	Denials of coverage for services the health plan determines do not meet requirements for medical necessity, appropriateness, health care setting, or level of care or effectiveness.
When you can appeal:	You may file after denial for coverage has been appealed and at any time through all levels of the health plan's internal process.
What to send:	Written request
What you must pay:	No charge
What will happen:	1. MDI checks that your request is appropriate for independent review. 2. MDI requests you and your health plan to submit all relevant and pertinent information within 20 days (although you may take longer if necessary). 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, 1-800-726-7390
www.insurance.state.mo.us

Montana

General Information:

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

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

The Independent Review Process:

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

How to Get More Information

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

Nebraska

General Information:

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

How to Get More Information:

Contact your health plan.

Nevada

General Information:

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

How to Get More Information:

Contact your health plan.

New Hampshire

General Information:

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

The External Appeal Process:

Whom to contact:	New Hampshire Insurance Department
Who can appeal:	You or anyone you have given consent to represent you including your health care provider.
What you can appeal:	Denials of coverage for services the health plan determines are not medically necessary or are experimental or investigational. The cost of the denied services is or is anticipated in a 12-month period to be equal to, or in excess of, $400.
When you can appeal:	You must file within 180 days of the date of the health carrier's second-level denial. Some exceptions allow you to file earlier, such as if the health plan agrees to file earlier or if the health plan does not meet time requirements for decisions.
What to send:	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, 1-800-852-3416
www.state.nh.us/insurance/

New Jersey

General Information:

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

The External Appeal Process:

Whom to contact:	New Jersey Department of Health and Senior Services
Who can appeal:	You, your doctor, or your authorized representative
What you can appeal:	Denials, reduction, termination, or limitations of covered health care services.
When you can appeal:	After denial for coverage has been appealed through the health plan's internal appeal process or the plan has not responded within the required deadlines, you must file within 60 days after your formal internal appeal is denied.
What to send:	A complete external appeal form (provided by your health plan) which asks for the following information: 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 business 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

New Mexico

General Information:

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

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

The External Review Process:

Whom to contact:	New Mexico Superintendent of Insurance, State Corporation Commission
Who can appeal:	You or your provider with written consent
What you can appeal:	Denials of coverage for services the health plan determines are not medically necessary or a coverage benefit.
When you can appeal:	You must file within 20 working days after receiving the written notice from the health plan's internal review. An expedited external review may be appealed concurrently with the internal appeal.
What to send:	Completed request form, including a medical records release.
What you must pay:	No charge
What will happen:	1. The Division of Insurance will complete the external review within 20 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 schedules 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:	20 days after receipt of the request for external review and all necessary documentation.
In urgent situations:	Within 72 hours for an emergency

How to Get More Information:

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

New York

General Information:

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

The External Appeal Process:

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

How to Get More Information:

New York State Insurance Department Hotline, 1-800-400-8882
www.ins.state.ny.us

North Carolina

General Information:

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

The External Review Process:

Whom to contact:	North Carolina Department of Insurance, Healthcare Review Program
Who can appeal:	Insured or authorized representative
What you can appeal:	External review is available when your health plan denies coverage for services or requested services on the grounds that they are not medically necessary.
When you can appeal:	You can file a request for external review within 60 days of receiving notice of your health plan's final decision from the highest level of appeal offered, or for expedited external review, within 60 days of receiving either the initial denial or decision on appeal.
What to send:	1. Completed external review request form, unless expedited request (which can be made orally or in writing), 2. Copy of notice of final determination denying coverage from insurer, 3. Signed medical authorization release form, and 4. Copy of your health insurance card.
What you must pay:	No charge
What will happen:	The Healthcare Review Program will: 1. Conduct a preliminary review of your request to determine eligibility for external review. Within 10 business days after requesting external review, you will receive notification whether the request is complete and whether it has been accepted for review. Your health plan and provider will be notified at the same time. 2. If accepted for review, your case will be assigned to an independent review organization (IRO). 3. For a standard review, you may provide written information to the IRO within 7 days after the date of notice of acceptance. That same information must be provided to your health plan by the same means as it was provided to the IRO. The Independent Review Organization will: 1. Have a medical expert(s) review the case. 2. Make a determination in writing in which you, your provider, and insurer are notified of the decision.
When you will get a decision:	External review is performed on either a standard or expedited timetable, depending on which is requested and on whether medical circumstances meet the criteria for expedited review. A decision is issued by the IRO within 45 days of the Healthcare Review Program receiving the request for standard reviews and 4 days for expedited reviews.
In urgent situations:	An expedited external review of a noncertification decision (denial) may be available only when having first completed your health plan's internal appeal process (even on an expedited basis) or receiving a standard external review through the Healthcare Review Program would put your life, health, or recovery in serious jeopardy.

How to Get More Information:

North Carolina Department of Insurance Healthcare Review Program
In State toll free: 877-885-0231, Local: 919-715-1163; www.ncdoi.com

North Dakota

General Information:

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

How to Get More Information:

Contact your health plan.

Ohio

General Information:

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

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

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

The External Review Process:

Whom to contact:	Your health plan
Who can appeal:	You, your provider (with consent), or your authorized representative
What you can appeal:	Denials, reductions, or terminations of coverage for services the health plan determines are (a) not medically necessary, (b) determined to be experimental or investigational and the enrollee has a terminal condition, or (c) questions of contract coverage (these are reviewed by the Superintendent of Insurance.)
When you can appeal:	After denial for coverage has been appealed through all levels of the health plan's internal process, within 60 days from receipt of the final adverse determination. Unless your case qualifies for expedited review, your cost for the denied services must exceed $500. For expedited review, your provider must explain why your medical condition is eligible. Questions of contract coverage and experimental/investigational reviews are not subject to the $500 certification.
What to send:	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 that would cost you $500 or more, the Superintendent will notify your health plan to either cover the service or provide an external review. If the case would cost less than $500, the case does not qualify for external review and is outside the Department's jurisdiction.
When you will get a decision:	The Independent Review Organization has 30 days to complete the review for a standard review and 7 days for an expedited review. There is no time frame in which the Superintendent must complete the review.

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

How to Get More Information:

Consumer Hotline, 1-800-686-1526
www.ohioinsurance.gov

Oklahoma

General Information:

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

The External Review Process:

Whom to contact:	Your health plan
Who can appeal:	You or your authorized representative
What you can appeal:	Denials of coverage for services costing more than $1,000 that the health plan determines are not medically necessary, medically appropriate, or medically effective.
When you can appeal:	After denial for coverage has been appealed through all levels of the health plan's internal process, you must file within 30 days from receipt of the final adverse decision.
What to send:	A written request
What you must pay:	$50 (refunded if the external reviewer decides in your favor). Additionally, some HMOs refund all external review fees regardless of outcome.
What will happen:	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

Oregon

General Information:

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

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

The External Review Process:

Whom to contact:	Contact your health plan
Who can appeal:	Anyone can request external review who is covered by a health benefit plan other than Medicare, the Oregon Health Plan, and employer self-insured plans.
What you can appeal:	You can appeal denials of coverage for services that the health plan determines are not medically necessary, are considered experimental or investigational, or that require continuity of care when a provider leaves your HMO.
When you can appeal:	After denial for coverage has been appealed through up to 3 levels of the health plan's internal process; you must request external review within 180 days from receipt of the final adverse decision.
What to send:	Send a written request for external review. If the patient is in serious danger of life-threatening injury or impairment pending a 30-day review process, the request should state "expedited review" and include testimony from a health care professional as to the potential danger.
What you must pay:	No charge; all costs are paid by the insurer
What will happen:	Your health plan will forward your request for external review to the State of Oregon's Insurance Division within 2 days. The Consumer Advocate Liaison will assign your case to an IRO and tell you which IRO will review your case. If there is a conflict of interest, you may challenge the choice of IRO within 2 days of receiving the notice by contacting the Consumer Advocate Liaison. The IRO will 1. Determine if your request qualifies for external review. 2. Accept additional information from you, your provider, or your health plan within 7 days. 3. Review your case and notify you and your health plan of its decision.
When you will get a decision:	For a standard review, you will receive a decision from the IRO within 30 days of your request for independent review.
In urgent situations:	You, your provider, or your health plan may submit additional information within 24 hours of an expedited request. An expedited review produces a decision within 3 days of your request.

How to Get More Information:
Oregon Department of Consumer & Business Services, Insurance Division, 503-947-7269
www.oregoninsurance.org/docs/consumer/health.htm

Pennsylvania

General Information:

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

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

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

The External Grievance Appeal Process:

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

How to Get More Information:

Complaints or Grievances: Bureau of Managed Care, 1-888-466-2787
Complaints: Pennsylvania Insurance Department, 1-877-881-6388

Rhode Island

General Information:

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

The External Review Process:

Whom to contact:	The review agent that rendered the adverse decision
Who can appeal:	You, your provider, or your authorized representative
What you can appeal:	Adverse decisions, which are decisions by a review agent not to certify a health care service.
When you can appeal:	After denial for coverage has been appealed through the 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

South Carolina

General Information:

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

The External Review Process:

Whom to contact:	Your health plan
Who can appeal:	You or your authorized representative
What you can appeal:	Denied health services that are not considered medically necessary, effective, appropriate, at the appropriate level of care, or provided in the appropriate setting. For conditions that are life threatening or seriously disabling, services considered experimental or investigational may be appealed. The amount payable for covered benefits must be at least $500.
When you can appeal:	For a standard review, you must apply within 60 days after receiving notice that your request for services has been denied. You must apply within 15 days for an expedited review.
What to send:	Request an external review in writing.
What you must pay:	No charge
What will happen:	Within 5 business days of receiving your request for external review, your health plan will either: 1. Assign your case to an independent review organization and send documentation to the review organization, or 2. 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 or final adverse termination. Within 5 business days of receiving the request for external review, the review organization will evaluate whether or not the necessary information has been received and notify you if additional information is needed. You must also submit additional information and documentation to support your case within 7 business days after receiving this notification. In general, the review organization will evaluate the documentation and make a decision. If your appeal concerns an experimental or investigational treatment, the review organization will select a review panel and the reviewers will submit written opinions. The review organization will then make a decision to uphold or reverse your health plan's determination. Decisions regarding denials of experimental or investigational treatments must be based on the recommendation made by the majority of the panelists.
When you will get a decision:	Within 45 days after the review organization receives the request from your health plan.
In urgent situations:	An expedited review is available if the patient has a serious medical condition or is requesting continued care after receiving emergency treatment. You must apply for expedited review within 15 days of receiving notice that your request for services has been denied. A decision will be made no more than 3 business days after the request was received by the health plan.

How to Get More Information:
Department of Insurance, Consumer Services Division, 1-800-768-3467 or 803-737-6180
www.doi.state.sc.us

South Dakota

General Information:

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

How to Get More Information:

Contact your health plan.

Tennessee

General Information:

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

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

The Independent Review Process:

Whom to contact:	Your health plan
Who can appeal:	You or your authorized representative
What you can appeal:	Denials of coverage for services the health plan determines are not medically necessary or are experimental. The cost of the proposed service to the health plan must be at least $500.
When you can appeal:	After completing the HMO internal grievance process, within 60 days of receiving final notification that coverage will be denied.
What to send:	A written letter including any pertinent documentation
What you must pay:	Up to $50 for independent review
What will happen:	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

Texas

General Information:

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

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

The Independent Review Process:

Whom to contact:	Your health plan or its utilization review agent
Who can appeal:	You, your provider, or your authorized representative (although only you or your legal guardian may sign a medical records release form).
What you can appeal:	Prospective or concurrent denials of coverage for services that the health plan or its utilization review agent determines are not medically necessary or appropriate.
When you can appeal:	After denial for coverage has been appealed through the health plan's or its utilization review agent's internal process, or immediately to the IRO if you have a life-threatening condition. There is no time limit.
What to send:	A completed independent review request form (the health plan or its utilization review agent is required to provide you with this form at the time it denies services and again if your appeal is denied). Send to your health plan or its utilization review agent at the address or fax number listed at the bottom of the request form.
What you must pay:	No charge
What will happen:	1. The health plan or its utilization review agent 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 receiving a complete IRO request. 3. The Department will notify the patient and the providers 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, 1-800-252-3439 (463-6515 in Austin)
www.tdi.state.tx.us

Utah

General Information:

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

The Independent Review Process:

Whom to contact:	Your insurance carrier
Who can appeal:	You or your authorized representative
What you can appeal:	Adverse benefit determinations of medical necessity.
When you can appeal:	You may appeal within 180 calendar days from the date of the final review decision of the internal review process
What to send:	Independent reviews need to be requested in writing, while expedited reviews may be submitted orally or in writing. You will want to provide the insurer with as much information as possible so the independent review organization can conduct a complete and fair review.
What you must pay:	No charge
What will happen:	Your request for a review will be handled as an independent review, unless there is an urgent medical situation and then it will be handled as an expedited review. Independent reviews: 1. You must exhaust the insurers internal review process unless you and the insurer mutually agree to waive the internal process. 2. You must send your insurer a written request for an independent review within 180 days from the date of the final internal review decision. 3. Your insurer will select an Independent Review Organization to conduct the review. 4. Your insurer will send you notification of the Independent Review Organization's decision. This notification will include the reasons for the decision, reference to the specific plan provision on which the decision is based. 5. The independent review decision is binding and final. Expedited reviews: 1. You may submit a request for an expedited review either orally or in writing. If your insurer receives an oral request for an expedited review, the insurer will send you a written confirmation of the request within 24 hours. 2. Your insurer will select an Independent Review Organization to conduct the review. 3. Your insurer will send you notification of the Independent Review Organization's decision. This notification will include the reasons for the decision, reference to the specific plan provision on which the decision is based. 4. The expedited review decision is binding and final.
When you will get a decision:	Within 30 days for an Independent Review of a pre-service claim, and within 60 days for a post-service claim
In urgent situations:	The insurer will notify you as soon as possible, but no later than 72 hours after receiving your request for an expedited review.

How to Get More Information:
Utah State Insurance Department,
801-538-3805 (Salt Lake City), 1-800-439-3805 (other Utah areas), 801-538-3826 (TDD)
www.insurance.utah.gov

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 assigns your case on a rotating basis to an independent review organization. 4. The Division will ask you and your health plan to send it the pertinent documentation within 10 days. Your health plan may request an extension of up to 10 days for good cause. You may request an extension for any reason. 5. The Division will send you and your health plan the documentation provided by the other party. You and your health plan have 3 days from receiving the information to send a response to the Division. 6. After the documentation and responses have been received, the Division will send all of the documentation to the independent review organization assigned to your case. 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

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, 1-800-552-7945 (in Virginia only), 804-371-9206 TDD
www.state.va.us/scc/division/boi

Washington

General Information:

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

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

The Independent Review Process:

Whom to contact:	Your health plan
Who can appeal:	You or your authorized representative
What you can appeal:	Denials, modifications, reductions, or terminations of either coverage or payment for health care services.
When you can appeal:	After you have exhausted your health plan's internal grievance procedure and have received an unfavorable decision, or if your health plan has exceeded the timelines for the internal procedure without good cause.
What to send:	Oral or written request. Each carrier must provide a clear explanation of the process upon request, upon enrollment to new enrollees, and annually to enrollees.
What you must pay:	No charge
What will happen:	1. Your health plan will select a certified independent review organization from the Insurance Commissioner's designated rotational registry. 2. Your health plan will provide the pertinent documentation to the review organization within 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, 1-800-562-6900
www.insurance.wa.gov

West Virginia

General Information:

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

The External Review Process:

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

How to Get More Information:

Contact your health plan.

Wisconsin

General Information:

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

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

The Independent Review Process:

Whom to contact:	Your health plan
Who can appeal:	You or your authorized representative
What you can appeal:	Denials of coverage for services the health plan determines are not medically necessary, appropriate, or effective, services that are not provided in the required health care setting, or services that are experimental. The amount in dispute must exceed $250.
When you can appeal:	After denial for coverage has been appealed through the health plan's internal process, you must file within 4 months from receipt of the final adverse determination or experimental treatment determination.
What to send:	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 your 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:

1-800-236-8517 (in Wisconsin)
www.oci.wi.gov

Wyoming

General Information:

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

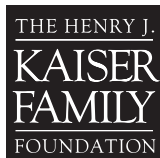
How to Get More Information:

Contact your health plan.

Consumers Union

Consumers Union
101 Truman Ave
Yonkers, NY 10703
Phone: 914-378-2000

www.consumersunion.org



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