EXTERNAL REVIEW CONSUMER GUIDE

STATE OF CONNECTICUT
INSURANCE DEPARTMENT

Rev. 7-11

CONNECTICUT INSURANCE DEPARTMENT
EXTERNAL REVIEW CONSUMER GUIDE

OVERVIEW

Connecticut Public Act 11-58 gives you the right under specific circumstances to apply for an External Review for the denial, reduction, termination or failure to make payment under the health carrier's health benefit plan on the basis that:

1) The benefit does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, effectiveness of the health care service, or

2) The health carrier considers the drug, procedure or therapy to be experimental and or/investigational, or

3) The health carrier has made an adverse determination involving eligibility to participate in the health carrier's health benefit plan, or

4) The health carrier has rescinded coverage due to an alleged fraudulent act, practice or omission or the intentional misrepresentation of material fact.

Before you may apply for this review, you must have completed the grievance process outlined under your plan.

To guide you through this process, we have provided a brief overview of the grievance process starting with the denial of a claim by your insurance company/health plan or its utilization review company.

DENIAL OF CLAIM

Under the terms of health insurance plans, insurance companies or their utilization review companies are permitted to make decisions in regard to the medical necessity of treatments or services. The insurance company/health plan may decline to authorize services for you, as they have determined that they are not medically necessary based on an evaluation of the medical information submitted, or because they have determined that according to the health plan, the drug, procedure or therapy is considered experimental and/or investigational. Members have the right to appeal these decisions as outlined below.

INTERNAL APPEALS THROUGH YOUR INSURANCE COMPANY/HEALTH PLAN

Covered persons who are declined services by their health insurance carrier or who have received an adverse determination related to eligibility to participate in the health carrier's plan or a rescission of coverage, have the right to appeal decisions through the carrier's internal grievance process.

In addition, covered persons may be eligible for an expedited appeal for urgent care requests, if the time frame for making a standard determination could seriously jeopardize the life or health of the covered person, or their ability to regain maximum function, or if the treating physician certifies that the covered person would be subjected to severe pain that cannot adequately be managed without the health care service or treatment being requested.

Information on the grievance procedure is included with all denial letters sent by the health insurance carrier. Members should follow these procedures when appealing their denial.

If the final appeal results in the denial of services or results in a carrier determination to confirm the denial of eligibility in the health plan or rescission of coverage, your plan must notify you of your rights under External Review.

Please note: If the services are denied because they are not a covered benefit under your plan, or your benefits for this service have reached their limit, then the grievance process is concluded after your final internal appeal and no further appeal or review is allowed under the plan.

EXTERNAL REVIEW THROUGH THE CONNECTICUT INSURANCE DEPARTMENT

Once the covered person's internal grievance process is exhausted through the insurance company/health plan, the covered person may request an independent review through the External Review Program. The External Review process was set up in the State of Connecticut to mediate disputes regarding the medical necessity of a covered benefit or service, including experimental and/or investigational services, and other disputes involving eligibility and rescission of coverage.

The Connecticut Insurance Department contracts with independent review organizations to perform medical reviews of the denied services, as well as reviews of other eligible grievances. Based on their impartial review, the independent review organization determines whether the medical services are medically necessary and should be approved, or if the eligibility or rescission determination by the health carrier should be reversed. The decision of the independent review organization is independent of the insurance company/health plan and the State of Connecticut Insurance Department, and the decision is binding.

EXPEDITED EXTERNAL REVIEW

Under the Connecticut External Review Program, covered persons may apply for an expedited external review of the denial of medical services when it is determined that the time frame for completion of an expedited internal appeal of the denial of services may seriously jeopardize the life or health of the covered person, or would jeopardize the covered person's ability to regain maximum function. This expedited external review is available immediately following the initial adverse determination or following any level of adverse internal appeal determination. The covered person does not have to exhaust his/her internal appeals before applying.

To qualify for an expedited appeal, the covered person must have his/her treating physician complete the Physician Certification Form attached to the "Request for External Review" application. Appeals for services already provided will not be considered for an expedited external review.

Please note that an expedited external review may be filed at the same time as an expedited internal review, except that the independent review organization will determine whether the covered person shall be required to complete the expedited internal review prior to conducting the expedited external review.

ELIGIBILITY FOR EXTERNAL REVIEW

To be eligible for the external review process through the State of Connecticut Insurance Department, you must satisfy the following requirements:

► **You must have exhausted the internal appeal process of your health plan.**

Your insurance company/health plan or utilization review company acting on behalf of your insurance company/health plan is required to provide you with written notification that you have exhausted the internal appeal process.

This requirement is waived for expedited external reviews. You have the right to file an expedited external review immediately following any adverse determination or following any adverse internal appeal determination.

► **You must file your External Review within 120 days.**

Your completed "Request for External Review" must be filed with the Insurance Department within 120 days of receiving the written notification that the internal appeals have been exhausted.

For expedited appeals, you may file immediately after the initial adverse determination or following any adverse internal appeal determination.

► **You must be actively enrolled in your health care plan at the time the service was requested as well as when the service is provided.**

► **The External Review is for a service or procedure that is covered in your contract.**

You may only use this external review process to appeal for services that are covered in your contract. The review process cannot be used to expand the coverage of your contract. For example, this process cannot be used to authorize coverages that are exclusions in your contract. Be sure to review the listed exclusions in your contract.

► **The denial of medical treatment or services must be based on certain criteria.**

To qualify for External Review the denial of medical treatment or services must be based on medical necessity, appropriateness, health care setting, level of care, effectiveness of the health care service, experimental and or/investigational determination, or must involve an adverse determination involving eligibility to participate in the health carrier's health benefit plan, or a rescission of health coverage.

► **The group or individual medical policy must be written in the State of Connecticut.**

► **Your insurance company/health plan must be a fully insured plan or you must be enrolled in the State of Connecticut Employee Health Plan to be eligible.**

"Self-insured" plans are not included in the Connecticut External Review Program. Your employer can tell you if your plan is "self-insured" and direct you to any grievance options available under your plan.

► **Your appeal cannot be for Workers' Compensation, Medicaid, Medicare or a Medicare Risk program claim.**

FILING THE EXTERNAL REVIEW

You, or your provider with your written consent, may request an external review. The "Request for External Review" application and all supporting documents for the external review must be filed with the Insurance Department within 120 days of receiving the final denial letter.

The following items must be included in your application, as your review will be rejected if all of these items are not included:

» **Application -** Completed “Request for External Review” application

» **ID Card -** Copy of the patient’s insurance identification card

» **Final Denial Letter -** Copy of the final denial letter from the insurance company/health plan or utilization review company denying your request at the final level of their internal appeals process.
(For Expedited External Reviews attach the last denial letter received.)

» **Filing Fee - C**heck or money order for $25 made payable to “Treasurer, State of Connecticut” or a Request for Waiver of the Filing Fee*

» **Physician Certification Form Required for:**

- Expedited External Review
- Request for review of Experimental/Investigational Denials

» **Any New Medical Information (Optional) -** It is the applicant’s responsibility to provide any additional new medical information that he/she wishes to have considered as part of the external review.

Please Note: All medical records submitted during the Insurance Company/Health Plan’s appeal process will be forwarded automatically to the independent review organization reviewing your case by your insurance company/health plan.

Waiver of Filing Fee Guidelines

The filing fee will be waived by the Insurance Commissioner for indigent individuals or those individuals who are unable to pay the $25 fee. Indigent individual means an individual whose adjusted gross income (AGI) for the individual and spouse from the most recent federal tax return filed, is less than two hundred percent of the federal tax poverty level. In addition, the filing fee is waived for any covered person who has already paid the maximum fee of $75 per calendar year.

# of Family Members	200% of 2011 Federal Poverty Level
1	$21,780
2	$29,420
3	$37,060
4	$44,700
5	$52,340
6	$59,980
7	$67,620
8	$75,260 *

THE EXTERNAL REVIEW PROCESS

The Insurance Department contracts with independent review organizations to review external review requests. Once your completed application is received, the Insurance Commissioner will send your request to the insurance company/health plan to conduct a Preliminary Review to determine if you meet the eligibility requirements for external review described in the "Eligibility for External Review" portion of this Consumer Guide. If the insurance company/health plan determines that you do not meet the eligibility requirements for external review, they will notify you of their decision in writing. If you disagree with this determination, you may file an appeal with the Insurance Commissioner who will make the final decision on eligibility.

If your application for External Review is accepted, the Insurance Commissioner will immediately assign an independent review organization to conduct a full review. The independent review organization is required to notify all parties of their decision within the following time frames:

- Standard External Review – 45 Days
- Experimental and/or Investigational Review – 20 Days
- Expedited Review – 72 hours
- Expedited Experimental and/or Investigational Review – 5 Days

The independent review organization will make one of the following decisions:

- Affirm the denial of services (accept the denial)
- Reverse the denial of the services (overturn the denial)
- Revise the denial of the services (partially overturn the denial)

You will be notified directly by the independent review organization of their decision and a copy of these findings will be shared with the Insurance Commissioner, the insurance company/health plan and your authorized representative, if applicable. If your appeal results in a "reverse" or "revise" determination, your insurance company/health plan will be responsible for reprocessing your claim according to the terms and conditions of your plan. In addition, the Insurance Department will refund the $25 application fee when a "reverse" or "revise" determination has been rendered.

All decisions of the independent review organization are final and the decision is binding. There is no provision for further appeal of this decision.

MAILING INSTRUCTIONS

Please mail your application for external review to:

Connecticut Insurance Department
Attn: External Review
P.O. Box 816
Hartford, CT 06142-0816

For overnight delivery only, please mail your application for external review to:

Connecticut Insurance Department
Attn: External Review
153 Market Street, 7th Floor
Hartford, CT 06103

FOR FURTHER INFORMATION

Please call (860) 297-3910 for additional copies of this brochure, or with any questions or concerns that you may have. This External Review Consumer Guide and the Request for External Review forms are also available on the State of Connecticut Insurance Department's Web site: www.ct.gov/cid.