State of Connecticut Insurance Department
External Review Program

Frequently Asked Questions about Appeals, External Review, and Independent Review Organizations (IRO)

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Introduction

This guide is designed to assist consumers who have been denied coverage for a treatment or service under their health insurance plan.

This overview provides information on the appeal process through the insurance company, as well as information on filing for an independent review through the State of Connecticut External Review Program.

Why was my request denied?

When you receive a denial notice, your insurance company is required to disclose to you the reason for the denial. These reasons might include:

- Services are considered not "medically necessary"
- Services are no longer needed in that health care setting or level of care
- The effectiveness of the health care services has not been proven
- Services are considered experimental or investigational for treatment of this condition
- Exception for out-of-network provider is not needed as adequate providers are available within the network

It is important to understand the reason why your request for services has been denied by your insurance company. This will enable you to work with your doctor to obtain medical documentation to support your need for these services.

What are my rights as a consumer if I am denied services?

If you receive a denial based on one of the reasons above, you have the right to appeal this decision to your insurance company for another review.

If you are unsuccessful, you have the additional right to have this decision reviewed by an Independent Review Organization through the State of Connecticut External Review Program.

How do I appeal this denial with my insurance company (Internal Appeal)?

If your insurance company denies your request for authorization of services, they must also inform you of your right to appeal this decision.

If you disagree with the decision of the insurance company, you have 180 days to file an appeal of this decision. Each denial letter from an insurance company will give you very specific information on how to file an appeal and where this request should be sent.

If you choose to file an appeal, it is important that you follow the appeals instructions printed in the denial letter and act within the designated timeframes. If you don't file your appeal within these timeframes, you lose your rights to further review of the decision.

What information is my insurance company required to provide?

To assist you in your appeal, you are entitled to request from your insurance company "free of charge" reasonable access to, and copies of all documents, records, and other information relevant to your request for services. Information on how to request this information is printed in your denial letter.

What information should I include when filing an appeal with my insurance company?

It is important that you include any materials that might support your need for the services in question, including any new supporting documents. You may also ask your treating physician to provide information that would be helpful to your appeal.

Important documents to submit with your appeal might include:

- A letter of support from your treating physician indicating the medical reasons that the requested service should be approved
- Treatment notes from your treating physician that provide information on the medical care provided to you
- The results of any relevant tests or procedures related to the requested service
- Your own personal narrative or the narrative of an authorized representative describing the need for the requested service
- For experimental or investigational treatments, any current medical literature or studies documenting the medical efficacy of the requested services

Whom may I contact for free assistance in preparing my appeal?

You have the right to free assistance in filing your appeal with the following state organization:

Office of the Healthcare Advocate
P.O. Box 1543
Hartford CT 06144
Telephone: 866-466-4446
Email: Healthcare.advocate@ct.gov
Website: www.ct.gov/oha

What should I do if my appeal for services is of an urgent nature?

All insurance companies are required to have a process in place for expedited handling of appeals for urgent care requests.

Urgent care appeals are available in any of the following situations:

- Standard timeframes for processing of a standard appeal would seriously jeopardize your life or health or your ability to regain maximum function
- Your treating physician feels that you would experience severe pain that cannot be adequately managed without these services
- Your request is for services related to a behavioral health or substance abuse disorder

Urgent Care Review of Specified Behavioral Health Services

If you are seeking services related to a substance abuse disorder or co-occurring mental disorder, your request will automatically be handled as an urgent care appeal. For services related to a behavioral health disorder, your request will be considered urgent for the following services:

- Inpatient Services
- Partial Hospitalization
- Residential Treatment
- Intensive Outpatient Service necessary to avoid an inpatient setting

Please Note: Urgent care appeals are not available when services have already been received.

Who reviews my appeal at the insurance company?

Your insurance company is required to select a clinical reviewer who is a physician or health care professional in the same or similar specialty as typically manages your medical condition, procedure, or treatment. For behavioral health or substance abuse services, a reviewer with a specified board certification in a specialty relevant to the requested services is required.

If my request is still denied and I have exhausted all my appeals with the insurance company, what are my rights to External Review?

Once you have exhausted all the mandatory internal appeals with your insurance company, you may file for an External Review. For urgent care requests, you may submit for an External Review immediately after any insurance company denial.

How do I know if I qualify for an External Review?

To be eligible for Connecticut's External Review Program you must meet the following criteria:

1. You must have exhausted the internal appeal requirements of your plan.

Your letter from the company will state that this is the "final determination". This is waived for urgent care requests.

2. The denial reason must qualify for an External Review.

If the denial reason in your final determination letter is related to medical necessary, an experimental/investigational review, eligibility, rescission of coverage, or an in-network exception; then your denial qualifies for consideration under the External Review Program.

3. The services you request must be covered under your plan.

Requests for External Review must be for services that are provided under your insurance plan. Contractual denials for non-covered benefits are not eligible.

4. You must file your complete External Review request within 120 days of the final determination letter.

It is important to file within the timeframes so that you retain your right to further review of this denial.

5. Your coverage must be provided by a fully insured plan issued in the State of Connecticut or you must be covered through the State of Connecticut employee plan.

Self-insured plans are not included in the Connecticut External Review Program. (See the glossary for a description of self-insured plans.) Your claims administrator can tell you if your plan is "self-insured" and if so, direct you to External Review options available to you under your plan.

How can I qualify for an expedited External Review?

The External Review Program provides for expedited handling of urgent care External Review requests. This is not available if services have already been received.

Expedited External Review requests are conducted when your provider certifies that:

- Standard timeframes for processing of a standard External Review would seriously jeopardize your life or health or your ability to regain maximum function; or

- Your treating physician feels that you would experience severe pain that cannot be adequately managed without these services.

If you are seeking services related to a substance abuse or behavioral health disorder, your request will automatically be handled as an expedited External Review.

What do I need to submit to request an External Review?

The External Review application has "Submission Instructions" to ensure that you submit all items that are necessary for acceptance of your request.

Required items to initiate an External Review are:

- Completed and signed External Review Application
- Copy of your medical insurance ID card
- Copy of the final denial letter from your insurance company. For expedited reviews, attach the last denial letter received.

For expedited requests only:

- Signed Physician Certification Form - *(waived for behavioral health or substance abuse denials)*

What medical information should I submit with my External Review?

Providing complete medical documentation gives you the best opportunity to have a thorough and comprehensive review of your request for services.

Your health plan will automatically transfer your appeals file to the independent review organization for inclusion in their External Review.

You should also be aware that you may ask your treating physician to provide any new information that would be helpful to your External Review.

Relevant information might include:

- A letter of support from your treating physician indicating the medical reasons that the requested service should be approved
- Treatment notes from your treating physician that provide information on the medical care provided to you to date
- The results of any relevant tests or procedures related to the requested service
- Your own personal narrative or the narrative of an authorized representative describing the need for the requested service
- For experimental or investigational treatments, any current medical literature or studies documenting the medical efficacy of the requested services

Who will review my External Review?

The Connecticut Insurance Department contracts with independent review organizations (IRO). Your External Review will be assigned to one of these contracted IROs.

IROs are independent organizations with no affiliation with your insurance company. This ensures that you receive an impartial review.

IROs are required to assign an individual clinical reviewer to your External Review who holds a license in the same or similar specialty as typically manages the medical condition under review. For appeals of behavioral health or substance abuse services, IROs are required to have a reviewer with a specified board certification in a specialty relevant to the requested services.

The clinical reviewer will review the following information:

- Any documents or information that your health plan used in making their determination
- Submitted medical records
- Consulting reports submitted by appropriate health care professionals
- Current practice guidelines and evidence-based standards for treatment of your condition
- Clinical review criteria used by your health plan
- Any other material submitted in support of your appeal

For medical necessity denials, the IRO will conduct a review and make a determination on whether the services are medically necessary and should be approved. For reviews involving eligibility, an in-network exception or rescission of coverage; the IRO will decide whether the insurance company's decision should be reversed.

The decision of the IRO is independent of the insurance company and the State of Connecticut Insurance Department.

How soon can I expect the decision on my External Review?

Based on the type of External Review request, the IRO will notify you of their decision within the timeframes as shown below.

Timeframes for External Review Decisions

- Standard – 45 Days
- Experimental/Investigational – 20 Days

Expedited External Reviews

- Behavioral Health or Substance Abuse – 24 Hours
- Experimental/Investigational – 5 Days
- All Other Expedited Requests – 48 Hours*

*72 hours if the 48-hour time-period falls on a weekend.

How will I be notified of the IRO's External Review decision?

You will be notified directly by the IRO of their decision and a copy will also be shared with the Insurance Department, the insurance company, and the treating physician listed in your application.

The IRO will make one of the following decisions:

- **Uphold** – confirms the denial
- **Reverse** – overturns the denial
- **Revise** - partially overturns the denial

If the IRO finds in your favor, then the insurance company is required to approve the services that were previously denied. All claims will be processed in accordance with the terms and conditions of your plan. All decisions of the IRO are final, and the decision is binding. There is no provision under state statute for any party to further appeal an IRO's External Review decision.

How often are External Review requests decided in favor of the consumer?

The External Review Program has been successful in helping consumers receive an independent and impartial review of their health insurance denials. It is important to note that historically nearly 40% of all denials are overturned through the program.

Where should I send my External Review request?

Please send your External Review to:

Connecticut Insurance Department
Attn: External Review
P.O. Box 816
Hartford CT 06142-0816
Email: insurance@ct.gov

What if I have further questions on the External Review process?

For information or an External Review Application:

Connecticut Insurance Department
Consumer Affairs Division
Telephone: 860-297-3910
Email: insurance@ct.gov
Website: www.ct.gov/cid

For free assistance in preparing your appeal:

Office of the Healthcare Advocate
Telephone: 866-466-4446
Email: Healthcare.advocate@ct.gov
Website: www.ct.gov/oha

Glossary of Health Coverage and Medical Terms

This glossary has many commonly used terms, but it isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs.

Appeal (Internal)

A request for your health insurance company to review a decision that denies a benefit or payment.

Authorized Representative

Someone who you choose to act on your behalf, like a family member or other trusted person. Authorized representatives must have your signed consent on the External Review Application to exercise your rights to an External Review.

Benefits

The health care items, or services covered under a health insurance plan. Covered benefits and excluded services are defined in the health insurance plan's coverage documents.

Claim

A request for payment for items or services that you or your health care provider submits to your health insurer.

External Review

A process where individuals may request an independent third-party review of a health plan's denial of a treatment or service under their plan.

An External Review either upholds the plan's decision or overturns all or some of the plan's decision. The health plan must accept this determination.

Medically Necessary

Health care services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.

Network

Facilities, providers, and suppliers your health insurer or plan has contracted with to provide healthcare services.

Prior Authorization

Approval from a health plan that may be required before you get a service or fill a prescription in order for the service or prescription to be covered by your plan.

Self-Insured Plan

Type of plan usually present in larger companies where the employer itself collects premiums from enrollees and takes on the responsibility of paying employees' and dependents' medical claims. These employers can contract for insurance services with a third-party administrator.