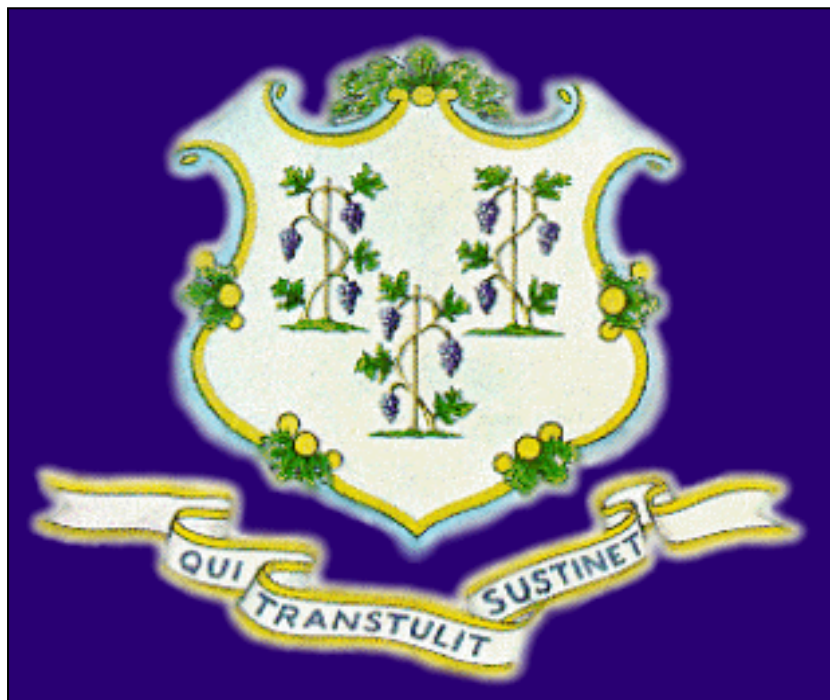


EXTERNAL APPEAL CONSUMER GUIDE



**STATE OF CONNECTICUT
INSURANCE DEPARTMENT**

CONNECTICUT INSURANCE DEPARTMENT

EXTERNAL APPEAL CONSUMER GUIDE

OVERVIEW

Connecticut General Statute Section 38a-478n gives you the right under specific circumstances to apply for an External Appeal for coverage of medical services or supplies denied to you by your insurance company/health plan on the basis of not being medically necessary. Before you may apply for this review, you must have completed the appeals process outlined under your plan.

To guide you through this process, we have provided a brief overview of the appeals 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. Members have the right to appeal these decisions as outlined below.

INTERNAL APPEALS THROUGH YOUR INSURANCE COMPANY/HEALTH PLAN

Members who are declined services by their health insurance carrier have the right to appeal decisions through the carrier's internal appeal process. Information on this appeal process is included with all denial letters sent by the health insurance carrier. Members should follow these procedures when appealing their denial. You should be aware that many insurance companies/health plans have more than one level of appeals available. If the final appeal results in the denial of services due to a determination that the services are not medically necessary, your plan must notify you of your rights under External Appeal.

Please note that if the services were denied because they are not a covered benefit under your plan or your benefits for this service have reached their limit, then the appeal process is concluded after your final internal appeal.

EXTERNAL APPEAL THROUGH THE CONNECTICUT INSURANCE DEPARTMENT

Once the member's internal appeal process is exhausted through the insurance company/health plan, members may request an independent review through the External Appeals Program. The External Appeal process was set up in the State of Connecticut to mediate disputes regarding the medical necessity of a covered benefit or service.

The Connecticut Insurance Department contracts with independent review entities to perform medical reviews of the denied services. Based on their independent review, the entities determine whether the medical services are medically necessary and should be approved. The decision of the external appeal reviewer is independent of the insurance company/health plan and the State of Connecticut Insurance Department and the decision is binding.

EXPEDITED APPEAL

Under the Connecticut External Appeals program, members may apply for an expedited appeal 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 cause or exacerbate an emergency or life threatening situation. This expedited appeal is available immediately following the initial adverse determination or following any level of adverse appeal determination. The member does not have to exhaust their internal appeals before applying.

ELIGIBILITY FOR EXTERNAL APPEAL

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

- **You must have exhausted the internal appeal process of your insurance company/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.

Please note that you may be eligible for an expedited appeal if the denial may cause or exacerbate an emergency or life threatening situation. If you qualify, you have the right to file an expedited external appeal immediately following any adverse determination.

- **Your completed "Request for External Appeal" application must be received by the Insurance Department within 60 days of receiving the written notification that the internal appeals have been exhausted.**

For purposes of this process, the number of days is based on calendar not business days. The 60 day time frame will commence 7 days after the date on the final denial letter, unless other evidence of a later receipt date is provided. Once this 60 day period expires, you will not be eligible for the external appeal process.

For expedited appeals, you may file immediately after the initial adverse determination or after any level of adverse 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.**
- **External appeal is only for a service or procedure that is covered in your contract.**
You may only use this external appeal process to appeal for services that are covered in your contract. The appeal 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 "medical necessity", health care setting, level of care or effectiveness.**
- **The group medical plan or individual medical policy must be written in the State of Connecticut.**
- **Your appeal cannot be for workers' compensation claims.**
- **Your insurance company/health plan cannot be a non-governmental "self-insured" plan.**
Your employer can tell you if your plan is "self-insured." The Insurance Department has no jurisdiction over "self-insured" plans. The Insurance Department's Consumer Affairs Division (1-800-203-3447) can direct you to the appropriate agency for assistance.
- **Your insurance company/health plan cannot be offered as part of a Medicaid, Medicare or a Medicare Risk program.**

FILING THE EXTERNAL APPEAL

You, or your provider with your written consent, may request an external appeal. The "Request for External Appeal" application and all supporting documents for the external appeal must be received by the Insurance Department within 60 days of receiving the final denial letter.

All medical records submitted during the carrier appeal process will be forwarded to the external appeal entity reviewing your case by your insurance company/health plan or utilization review company. It is the applicant's responsibility to provide any additional medical information that he/she wishes to have considered as part of the external appeal.

The following items must be included in your appeal. Your appeal will be rejected if all of these items are not included:

1. Completed "Request for External Appeal" application
2. Photocopy of the patient's insurance identification card
3. Copy of the letter from the insurance company/health plan or utilization review company indicating that their decision is final and all internal appeals have been exhausted. (For Expedited Appeals attach the last denial letter received.)
4. Non-refundable check or money order for \$25 made payable to "Treasurer, State of Connecticut"

Note: The fee will be waived by the Insurance Commissioner for indigent individuals or those unable to pay. Indigent individual means an individual whose adjusted gross income (AGI) for the individual and spouse, as certified on the request form, from the most recent federal tax return filed, is less than two hundred percent of the federal tax poverty level. The table below lists the 2009 poverty levels. If your AGI is below the figure corresponding the number of members in your family*, then the \$25 fee will be waived.

# of Family Members	200% of 2009 Federal Poverty Level
1	\$21,660
2	\$29,140
3	\$36,620
4	\$44,100
5	\$51,580
6	\$59,060
7	\$66,540
8	\$74,020 *

(*add \$7,480 for each additional family member)

Expedited Appeal

To qualify for an expedited appeal, the member must have his/her physician sign the authorization on the external appeals application indicating that the time frame for completion of an expedited internal appeal of the denial of services may cause or exacerbate an emergency or life threatening situation. The expedited appeal application may be filed with the Insurance Department immediately following the receipt of the insurance company/health plan or the utilization review company's initial adverse determination or at any level of adverse appeal determination. Appeals for services already provided will not be considered for an expedited external appeal.

The review entity will review all requests and will be responsible for granting approval for the expedited appeal. Applicants who are not accepted on an expedited basis, will automatically be considered for standard review if all internal appeals have been exhausted. If the expedited appeal is not accepted, and all internal appeals have not been exhausted, the applicant will not be accepted for external appeal and the applicant will be required to complete the remaining internal appeals available under the plan.

THE APPEAL PROCESS

The Insurance Department contracts with independent entities to review the appeal. Once a completed application is received, the Insurance Commissioner will assign the appeal to an external entity for review. The entity will conduct a preliminary review to determine the eligibility of the appeal. The entity will contact you and the Insurance Commissioner within 5 business days of its receipt (2 business days for expedited appeals) to notify you if your appeal meets the conditions described in the "Eligibility for External Appeal" portion of this brochure. If the appeal is rejected in the preliminary review phase, the external appeal process ends.

If the appeal is accepted for review, the reviewing entity will conduct a full review and forward its decision to the Insurance Commissioner within 30 business days of completing the preliminary review (2 business days for expedited appeals).

The reviewing entity 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)

The Insurance Commissioner shall accept the decision of the external appeal entity and notify you and the insurance company/health plan of its findings. 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" determination has been rendered.

All decisions of the external appeal entity 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 appeal to:

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

For overnight delivery only, please send your application for external appeal to:

Connecticut Insurance Department
Attn: External Appeals
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 Appeal Consumer Guide and the External Appeal Request form are also available on the State of Connecticut Insurance Department's Web site: www.ct.gov/cid