

**TABLE OF CONTENTS**

**External Appeals**

Applicability and scope . . . . .	38a-478n-1
Definitions . . . . .	38a-478n-2
External appeals . . . . .	38a-478n-3
External appeals entities. . . . .	38a-478n-4
Separability . . . . .	38a-478n-5

### External Appeals

#### **Sec. 38a-478n-1. Applicability and scope**

Nothing in Sections 38a-478n-1 to 38a-478n-5, inclusive, shall be construed to apply to:

(a) the arrangements of managed care organizations offered to individuals covered under self-insured employee welfare benefit plans established pursuant to the federal Employee Retirement Income Security Act of 1974; or

(b) any plan that provides for the financing or delivery of health care services solely for the purposes of workers' compensation benefits pursuant to chapter 568 of the general statutes.

(Adopted effective December 24, 1997; amended June 3, 2010)

#### **Sec. 38a-478n-2. Definitions**

As used in Sections 38a-478n-1 to 38a-478n-5, inclusive, of the Regulations of Connecticut State Agencies:

(a) "Adverse determination" means "adverse determination" as defined in section 38a-478(1) of the Connecticut General Statutes;

(b) "Authorized representative" means "authorized representative" as defined in section 38a-478n of the Connecticut General Statutes;

(c) "Business Day" means a day during which the state government of Connecticut conducts regular business;

(d) "Commissioner" means the Insurance Commissioner;

(e) "Covered benefit" or "benefit" means "covered benefit" or "benefit" as defined in section 38a-478(3) of the Connecticut General Statutes ;

(f) "Department" means the Insurance Department;

(g) "Enrollee" means "enrollee" as defined in section 38a-478n(a) of the Connecticut General Statutes;

(h) "Health insurer" means "health insurer" as defined in section 38a-478n(a) of the Connecticut General Statutes;

(i) "Health care services" means "health care services" as defined in section 38a-478(5) of the Connecticut General Statutes;

(j) "Indigent individual" means an individual whose adjusted gross income (AGI) for the individual and spouse, as certified by the individual on a form provided by the commissioner, from the most recent federal tax return filed is less than two hundred percent of the applicable federal poverty level;

(k) "Internal appeals" means the procedures provided by the utilization review company or managed care organization in which either the enrollee or provider acting on behalf of an enrollee may seek review of decisions not to certify an admission, procedure, service or extension of stay;

(l) "Managed care organization" means "managed care organization" as defined in section 38a-478(6) of the Connecticut General Statutes;

(m) "Managed care plan" means "managed care plan" as defined in section 38a-478(7) of the Connecticut General Statutes;

(n) "New information" means information that has not been previously made available to the managed care organization, health insurer or utilization review company for consideration when determining whether to certify an admission, service, procedure or extension of stay;

(o) "Preferred provider network" means "preferred provider network" as defined in section 38a-479aa of the Connecticut General Statutes;

(p) “Provider” or “health care provider” means “provider” or “health care provider” as defined in section 38a-478(9) of the Connecticut General Statutes;

(q) “Provider of record” means the physician or other licensed practitioner identified to the utilization review company, health insurer or managed care organization as having responsibility for the care, treatment and services rendered to an individual;

(r) “Review entity” means “review entity” as defined in section 38a-478(10) of the Connecticut General Statutes;

(s) “Standard External Appeal” means an external appeal that is not expedited.

(t) “Utilization review” means “utilization review” as defined in section 38a-226 of the Connecticut General Statutes; and

(u) “Utilization review company” means “utilization review company” as defined in section 38a-226 of the Connecticut General Statutes.

(Adopted effective December 24, 1997; amended August 30, 2004, June 3, 2010)

### **Sec. 38a-478n-3. External appeals**

(a) Any enrollee, or any provider acting on behalf of an enrollee with the enrollee’s consent, who, except for expedited external appeals, has exhausted the internal mechanisms provided by a managed care organization, health insurer or utilization review company to appeal the denial of a claim based on medical necessity or a determination not to certify an admission, service, procedure or extension of stay, regardless of whether such determination was made before, during or after the admission, service, procedure or extension of stay, may appeal such denial or determination to the commissioner. An enrollee or any provider acting on behalf of the enrollee with the enrollee’s consent may make a request to the commissioner for an expedited external appeal at the time the enrollee receives an adverse determination if: (1) The time frame for completion of an expedited internal appeal set forth in section 38a-226c of the Connecticut General Statutes may cause or exacerbate an emergency or life-threatening situation for the enrollee; and (2) the enrollee or the provider acting on behalf of the enrollee with the enrollee’s consent has filed a request for expedited review as set forth in section 38a-226c of the Connecticut General Statutes. (3) Upon receipt of such request and all required documentation, including the executed release and appropriate fee set forth in section 38a-478n(b) of the Connecticut General Statutes, the commissioner shall immediately assign the appeal for review to a review entity.

(b) To appeal a denial or determination pursuant to this section an enrollee or any provider acting on behalf of an enrollee with the enrollee’s consent shall, not later than sixty (60) days after receiving final written notice of the denial or determination from the enrollee’s managed care organization, health insurer or utilization review company, file a written request with the commissioner. The appeal shall be on forms prescribed by the commissioner and shall include the filing fee set forth in section 38a-478n of the Connecticut General Statutes, a general release executed by the enrollee for all medical records pertinent to the appeal and any other items the commissioner deems relevant for the appeal. The managed care organization, health insurer or utilization review company named in the appeal shall also pay to the commissioner the filing fee set forth in section 38a-478n of the general statutes. The commissioner shall waive the filing fee, on request, for individuals who demonstrate that they are indigent or unable to pay.

(c) For the purposes of sections 38a-478n-1 to 38a-478n-5, inclusive, of the Regulations of Connecticut State Agencies, not later than five (5) business days, or in the case of an expedited external appeal, not later than one (1) business day,

after receiving a written request from the commissioner, enrollee or any provider acting on behalf of an enrollee with the enrollee's consent, a managed care organization, health insurer or utilization review company whose enrollee is the subject of an appeal shall:

(1) provide to the commissioner, enrollee or any provider acting on behalf of an enrollee with the enrollee's consent, written verification of whether the enrollee's managed care plan or health insurance plan is fully insured, self-funded, or otherwise funded, and

(2) If the plan is a fully insured plan or a self-insured governmental plan, the managed care organization, health insurer or utilization review company shall send: (A) Written certification to the commissioner or review entity, as determined by the commissioner, that the benefit or service subject to the appeal is a covered benefit or service; (B) a copy of the entire policy or contract between the enrollee and the managed care organization or health insurer, except that with respect to a self-insured governmental plan, (i) the managed care organization or health insurer shall notify the plan sponsor, and (ii) the plan sponsor shall send, or require the managed care organization or health insurer to send, such copy; or (C) written certification that the policy or contract is accessible to the review entity electronically and clear and simple instructions on how to electronically access the policy.

(d) The commissioner shall assign the appeal to review entity for review. In making such an assignment the commissioner shall consider the level of expertise of the entity to review the particular procedure or service for which the certification was denied.

(e) Not later than five (5) business days, or in the case of an expedited external appeal, not later than two (2) business days, after receipt of the request for appeal from the commissioner, the review entity shall conduct a preliminary review of the appeal and accept it for full review if it determines that:

(1) the individual was or is an enrollee of the managed care organization or health insurer;

(2) the benefit or service that is the subject of the complaint or appeal reasonably appears to be a covered service or benefit under the agreement provided by contract to the enrollee and any benefit limitations have not been exhausted;

(3) for standard external appeals, all internal appeals have been exhausted, or in the case of expedited external appeal, the adverse determination may cause or exacerbate an emergency or life-threatening situation for the enrollee if not reviewed in an expedited time period; and

(4) the appeal includes all information required by the commissioner.

(f) Upon completion of the preliminary review, the review entity shall immediately notify the enrollee and provider of record by either electronic mail, facsimile machine or by overnight service as to whether the appeal has been accepted for full review and, if not so accepted, the reasons therefore. Not later than five (5) business days, or in the case of an expedited external appeal, not later than (1) business day from the date of such notice of acceptance for full review, the managed care organization, health insurer or utilization review company shall provide to such review entity by electronic mail, telephone, facsimile or other expeditious method all documents and information that were considered in making the adverse determination that is the subject of such appeal. In the case of a standard external appeal, the notification of acceptance for full review shall state the opportunity to submit new information such as is specified in subsection (g) of this section not later than five (5) business days after the date of such notice for consideration during its review. Upon receipt

of any additional information, the review entity shall determine if this is new information and if so, shall immediately contact the managed care organization, health insurer or utilization review company by electronic mail, facsimile, or telephone and notify them that new information has been presented. The review entity shall provide the managed care organization, health insurer or utilization review company with the new information either by electronic mail, facsimile machine or by overnight service. The managed care organization, health insurer or utilization review company shall have two (2) business days after receiving the new information to determine whether the absence of such new information contributed to the adverse determination. If the managed care organization, health insurer or utilization review company determines that the absence of such new information contributed to the adverse determination the managed care organization, health insurer or utilization review company shall have the opportunity to reverse its adverse determination. The managed care organization, health insurer or utilization review company shall promptly notify the review entity of its decision. If the managed care organization, health insurer or utilization review company decides to reverse its adverse determination, the review entity shall promptly notify the enrollee or provider of record and the commissioner that the managed care organization, health insurer or utilization review company has reversed the adverse determination based upon the new information. Any reversal of an adverse determination by a managed care organization, health insurer or utilization review company based upon new information shall not be considered a reversal by the commissioner for the purposes of the reporting requirements established by section 38a-478a of the Connecticut General Statutes.

(g) Upon acceptance of the appeal for review, the review entity shall conduct a full review to determine whether the adverse determination should be reversed, revised, or sustained. Such review shall be performed by a provider who is a specialist in the field related to the condition that is the subject of the appeal. The reviewing provider may take into consideration:

- (1) pertinent medical records,
- (2) consulting reports from appropriate health care professionals and other documents submitted by the health insurer, enrollee, the enrollee's authorized representative or the enrollee's provider,
- (3) practice guidelines developed by the federal government, national, state or local medical societies, boards or associations,
- (4) clinical protocols or practice guidelines developed by the utilization review company or managed care organization, and
- (5) such other criteria as set forth in section 38a-478n(e)(5) of the Connecticut General Statutes.

(h) The review entity shall complete its review and forward its decision to affirm, revise, or reverse the adverse determination to the commissioner not later than thirty (30) business days, or in the case of expedited external appeal, not later than two (2) business days, of completion of the preliminary review together with a report of its review. The review entity may request an extension of time from the commissioner within which to complete its review as may be necessary due to circumstances beyond its control. If an extension is granted, the review entity shall provide written notice to the enrollee or provider, setting forth the status of its review, the specific reasons for the delay and the anticipated date of completion of the review.

(i) The commissioner may reassign an appeal to another review entity if the commissioner determines (1) that a conflict of interest exists which may negatively impact the objectivity of the review entity to which the appeal was initially assigned

or (2) that the review entity to which an appeal was assigned is unable to complete its review within a reasonable time.

(j) The commissioner shall accept the decision of the review entity and notify the enrollee or provider and the utilization review company, health insurer or managed care organization of the decision, which shall be binding. The report of the review entity's review shall be made available to the enrollee or provider and the utilization review company, health insurer or managed care organization. The decision of the review entity shall not be construed as authorizing services in excess of those that are contractually provided for in the enrollee's managed care plan or health insurance plan.

(k) The request for appeal submitted by the enrollee or provider of record, the associated materials received by the managed care organization, health insurer or utilization review company, the decision of the review entity, and communication by and between the commissioner, the review entity and the enrollee shall be maintained as confidential information protected by section 38a-8 of the Connecticut General Statutes.

(Adopted effective December 24, 1997; amended August 30, 2004, June 3, 2010)

#### **Sec. 38a-478n-4. External appeals entities**

(a) The commissioner shall enter into agreements for external appeals services with as many review entities as he deems necessary after consultation with the Commissioner of Public Health. The agreements shall set forth all terms which the commissioner deems necessary to assure a full and fair review of appeals. Selection of a review entity shall include, but not be limited to, the criteria set forth in section 38a-478n of the Connecticut General Statutes.

(b) After entering into an agreement with the commissioner, the review entity shall report changes in its ownership, operational or administrative status to the commissioner not later than thirty (30) days after the effective date of such change. If the commissioner determines that the reported change(s) may negatively impact the effectiveness or objectivity of the review entity, the commissioner reserves the right to terminate the agreement.

(c) Any agreement may be terminated without cause by either party upon fifteen (15) days written notice, except that the commissioner may terminate an agreement with a review entity if such review entity is not satisfying the minimum qualifications set forth in section 38a-478n of the Connecticut General Statutes.

(Adopted effective December 24, 1997; amended June 3, 2010)

#### **Sec. 38a-478n-5. Separability**

If any provision of Sections 38a-478n-1 to 38a-478n-4, inclusive, or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of these regulations, and the application of such provision to other persons or circumstances, shall not be affected thereby.

(Adopted effective December 24, 1997)