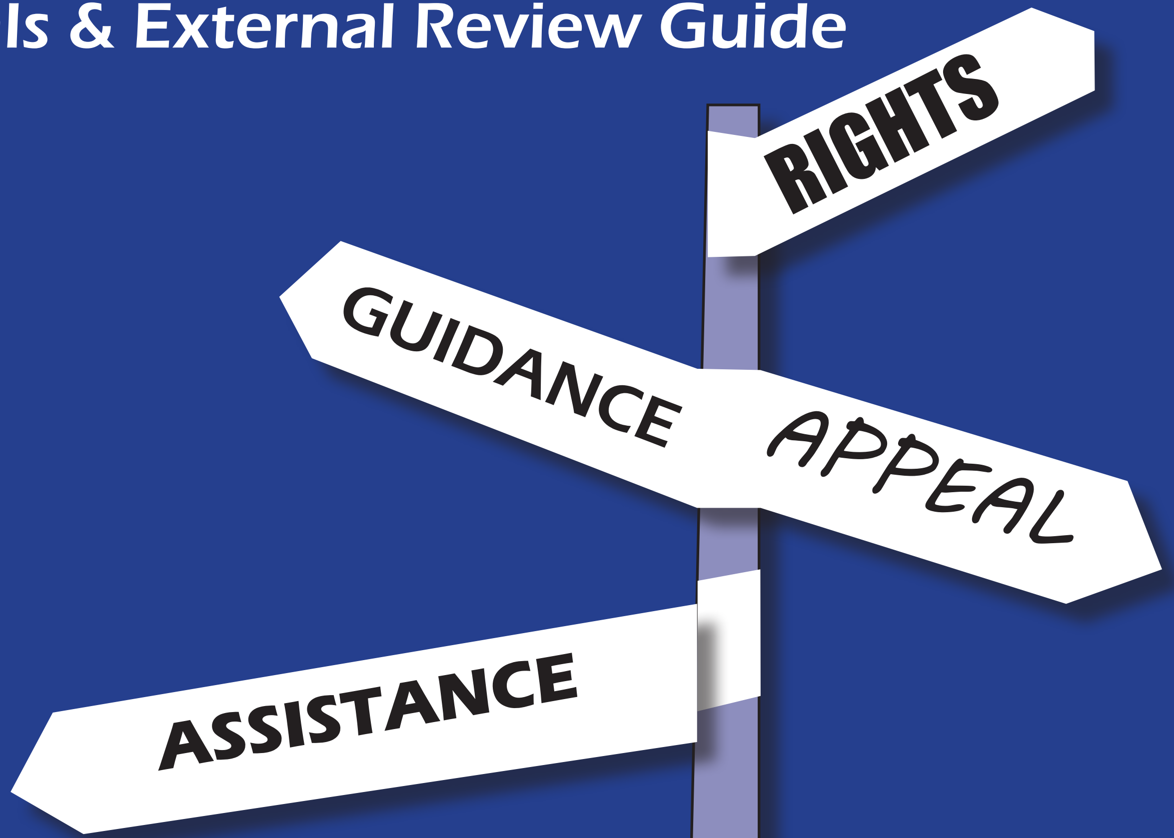
STATE OF CONNECTICUT
Insurance Department
Appeals & External Review Guide



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A Consumer's Guide to Appealing Health Insurance Denials

Introduction

This guide is designed to assist consumers who have been denied coverage or reimbursement for services under their health insurance plan. This overview provides information on the appeal process through your 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 deemed 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/investigational for treatment of this condition

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 the reasons above, you have the right to appeal this decision to your insurance company for another review(s).

If you are unsuccessful, you have the additional right to have this decision reviewed by an Independent Review Organization which is not connected to your insurance company by applying for the State of Connecticut External Review Program.

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

When your insurance company sends you notification that they have denied your pre-authorization or claims request, 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 a grievance (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 upon request?

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 is helpful to submit to my insurance company when filing an appeal?

It is important that you send supporting documentation to your insurance company with your appeal. You should be aware that you have the right to ask your treating physician to provide information that would be helpful to your appeal.

Important information 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

Where may I receive free assistance in preparing my appeal?

You have the right to assistance in filing your appeal from the following State agencies:

Connecticut Insurance Department
P.O. Box 816
Hartford CT 06142
Consumer Affairs Unit - 800-203-3447
www.ct.gov/cid
insurance@ct.gov

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

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 urgent care appeal requests.

Urgent care appeal requests are conducted when you or your provider believes that:

- Standard timeframes for processing of a standard appeal 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; or
- Your request is for a behavioral health service described below in Table 1.

Table 1
Urgent Care Review of Specified Behavioral Health Services

If you are seeking services related to a substance use disorder or co-occurring mental disorder, your request will automatically be handled as an urgent care appeal. For services related to a mental 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 rendered.*

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 appeals of certain behavioral health services as shown in Table 1, insurance companies are required to have a reviewer with a specified board certification in a relevant specialty to the requested services.

What if my appeal to the insurance company for a reconsideration of their initial denial is unsuccessful?

Check the appeal determination letter from your insurance company to see if there are any additional appeals remaining with the insurance company. Some insurance companies have one level of internal appeal, while others have a second level internal appeal, which is often voluntary.

Once you have exhausted your insurance company's internal appeal process, you may file a request for External Review. Individuals who request an urgent care appeal do not need to complete their insurance company's internal appeal process prior to requesting an external review.

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 External Review immediately after any insurance company denial.

The External Review process is a protection for consumers who disagree with the determination of their insurance company. The Connecticut Insurance Department contracts with independent review organizations to conduct an independent and impartial review of the request for services to determine if the correct claims determination was made by the insurance company.

The decision of the independent review organization is binding on all parties. This means that if the independent review organization finds in favor of the applicant, then the insurance company is required to approve the services that were previously denied.

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

To be eligible for Connecticut's External Review 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".

** Urgent care requests are exempt from this requirement.*

2. The denial reason must qualify you for an external review.

If the denial reason listed in your final determination letter is "not medically necessary", experimental/investigational, eligibility denial, or a rescission of your policy, 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.

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

4. You must file your complete 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. Your employer can tell you if your plan is "self-insured" and direct you to any grievance and external review options available under that plan.

How can I qualify for an expedited External review?

The External Review Program provides for expedited handling of urgent care External Review requests.

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; or
- If you are seeking services related to a substance use disorder or a co-occurring mental disorder, your request will automatically be handled as an expedited External Review. For services related to a mental disorder, your request will be expedited for the following services: Inpatient Service, Partial Hospitalization, Residential Treatment or Intensive Outpatient Service necessary to avoid an inpatient setting. See Table 1.

Please Note: Expedited External Reviews are not available when services have already been rendered.

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

The External Review application has an "External Review Checklist" to ensure that you submit all information that is necessary for acceptance of your request. The required items to initiate an External Review are:

- 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.*
- $25 Filing Fee or a Request for Waiver of the Filing Fee based on Federal Poverty Level Table 2 below.

** Your insurance company is required to provide you with a free copy if you do not have these items.*

For expedited requests, your medical provider must complete a Physician Certification Form attesting to the need for an expedited process. However, certain behavioral health services as shown in Table 1 are automatically reviewed on an expedited basis and do not require a physician signature.

For external reviews involving a denial of services as Experimental/Investigational service, your medical provider must complete a Physician Certification Form attesting to the recommended experimental treatment.

What if I can't afford the $25 Filing Fee?

The filing fee will be waived by the Insurance Department for any indigent individual or those individuals who are unable to pay the $25 fee. An indigent individual means an individual whose adjusted gross income (AGI) is less than 200% of the federal poverty level as shown in Table 2 below.

In addition, the filing fee is waived for any covered person who has already paid the maximum fee of $75 per calendar year.

Table 2

Guidelines for Waiver of Filing Fee

Number of family members	200% of 2020 Federal Poverty Level
1	$25,520
2	$34,480
3	$43,440
4	$52,400
5	$61,360
6	$70,320
7	$79,280
8	$88,240 *

** Add $8,960 for each additional family member*

What medical information should I submit with my External Review?

Along with your request for an External Review, you have the opportunity to submit additional medical documentation that has not been submitted previously. Providing complete medical documentation gives you the best opportunity to have a thorough and comprehensive review of your request for services.

Please Note: All previously submitted medical information submitted by you or your treating physician to the insurance company, as well as all documents or information that your insurance company considered in making their determination, will automatically be sent to the Independent Review Organization for consideration in the external review.

You should be aware that you have the right to ask your treating physician to provide new information that would be helpful to your external review. This 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 Insurance Department contracts with Independent Review Organizations (IRO) to perform all External Reviews. 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 certain behavioral health services as shown in Table 1, IROs are required to have a reviewer with a specified board certification in a relevant specialty to the requested services.

The clinical reviewer will review the following information:

- Any documents or information that your health carrier 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

The IRO will conduct an impartial review and make a determination on whether the medical services are medically necessary and should be approved, or if the review involves an eligibility or rescission determination by the health plan, whether the insurance company decision should be reversed.

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

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

When your External Review request is assigned to the Independent Review Organization (IRO), your health plan will automatically transfer your appeals file to the IRO for inclusion in their review. The IRO's clinical reviewer will then conduct an independent review.

Based on the type of External Review request, the IRO will notify you of their decision within the timeframes as shown in Table 3 below.

Table 3

Timeframes for External Review Decisions

Standard External Review	45 Days
Experimental/Investigational Reviews	20 Days
Expedited External Reviews	
Specified Behavioral Health Reviews	24 Hours
Experimental/Investigational	5 Days
All Others	48 Hours*

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

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

The IRO will make one of the following decisions:

- Uphold the denial of services
- Reverse the denial of services (overturn the denial)
- Revise the denial of services (partially overturn the denial)

You will be notified directly by the IRO of their decision and a copy of their decision will also be shared with the Insurance Department, the insurance company and your treating physician. If your determination results in a "reverse" or "revise" decision, your insurance company will be responsible for reprocessing your claim in accordance with the terms and conditions of your plan. In addition, your $25 application fee will be refunded to you when the determination is "reverse" or "revise".

All decisions of the IRO are final and the decision is binding on all parties. There is no provision under External Review for further appeal of this decision.

How often are External Reviews successful in overturning an insurance company's determination?

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 approximately 40% of all denials are overturned through the program.

Where should I send my External Review request?

Please mail your External Review to:

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

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

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

For information on the External Review program:

Connecticut Insurance Department
Consumer Affairs Unit - 1-860-297-3910
www.ct.gov/cid
insurance@ct.gov

For free assistance with preparing your appeal:

Office of the Healthcare Advocate
1-866-466-4446
www.ct.gov/oha
Healthcare.advocate@ct.gov