STATE OF CONNECTICUT

INSURANCE DEPARTMENT

Bulletin HC-68
June 4, 2008

TO: All Managed Care Organizations, Health Insurers and Utilization Review Companies Licensed in Connecticut

RE: External Appeal Process and Procedures

The purpose of this Bulletin is to provide guidance regarding the applicability of the statutory external appeals process and notification requirements regarding such process.

Sections 38a-478m (3) and 38a-478n of the Connecticut General Statutes require that an external appeal be available to enrollees and providers (with the enrollee's written consent) when a request for prior authorization, concurrent treatment or a retrospective claim is denied on the basis that the service, admission procedure or extension of stay is not medically necessary, including whether the service under review is considered experimental or investigational.

If the denial is based on a utilization review decision (before or during treatment), each notice (initial denial through final appeal) must contain a provision in **bold type** which informs the enrollee of the right to an external appeal. Such provision must include the following language:

a) the enrollee must first exhaust all of the utilization review company's or health insurer's internal appeals mechanisms;

b) the external appeal must be filed with the Insurance Department ("Department") within sixty (60) days of the utilization review company's or health insurer's final decision;

c) the external appeals process is not available to enrollees who are covered under a non-governmental self-insured plan or to denials regarding workers compensation; and

d) the enrollee may contact the Connecticut Insurance Department at Post Office Box 816, Hartford, CT 06142-0816, Telephone (860) 297-3910.

If the denial is a retrospective claim denial based on medical necessity, the final denial letter must include the four provisions noted above.

All final denial letters must also include:

- A notice stating that all internal appeals have been exhausted;
- The diagnostic codes (ICD-9/CPT) relating to the denial; and
- A copy of the external appeals guide and application.

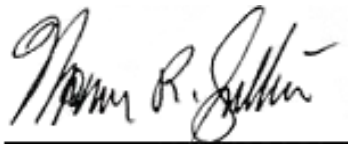
When a service, procedure, admission or extension of stay is denied on the basis of a clear contract exclusion rather than medical necessity, the denial letter must **explicitly** state the basis of the denial in plain language and indicate the provision in the contract where the exclusion is located. In these instances the language regarding the external appeals process should not be included. However, there may be situations when a medical determination was used to determine whether the service was a covered benefit. Examples include, but are not limited to:

- surgery which the company deems is cosmetic in nature;
- care the company deems is custodial rather than skilled or rehabilitative;
- requests by an enrollee to seek treatment out of network in an HMO plan because the enrollee asserts there is no provider in-network to treat the covered condition;
- off-label use, or use inconsistent with FDA approval, of drugs;

In these instances, external appeal language must be included in the denial letter and these denials are subject to external review.

Section 38a-478n (b) (4) (C) of the Connecticut General Statutes requires that the enrollee exhaust all internal appeal mechanisms available before an external appeal may be filed with the Department. There have been instances brought to our attention of situations where a provider has filed an appeal pursuant to the provider's contract with the carrier and when denied, filed an external appeal with the enrollee's written consent, bypassing the enrollee's appeals mechanisms. As all internal appeals available to the enrollee have not been exhausted, the case is not eligible for external appeals at that time. Denial letters sent to network providers who file a contractual appeal must be amended to explicitly state that the enrollee must first exhaust all appeals available before an external appeal is filed. In order to expedite the process, the Department recommends that the companies allow the provider appeal to be considered the enrollee's first level appeal and require only that any subsequent appeals be filed by the enrollee or his representative.

Questions may be directed in writing to the Department's Consumers Affairs Division at ctinsdept.consumeraffairs@ct.gov.



Thomas R. Sullivan
Insurance Commissioner