STATE OF CONNECTICUT

INSURANCE DEPARTMENT

Bulletin HC-74
September 16, 2009

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

RE: Public Act 09-49 – Amended External Appeal Law

Public Act 09-49, which amended the existing external appeal statute, is effective October 1, 2009. The amendments to the existing law enhance the Insurance Department's external appeal program by adopting the NAIC Model Law's provisions on expedited appeals, firming up quality control standards and clarifying situations when a provider may initiate an appeal. The Insurance Department's core program as it exists today is continuing, and the changes are enhancements and clarifications that have been added to improve the consumer protections provided.

Among the improvements being added to the external appeals statute:

- It adopts provisions for expedited external reviews when needed in life threatening and emergency situations.
- It adopts NAIC language on standards and the selection process of external review entities. These standards include quality controls, ability to meet time frames and to electronically receive data after hours, standards of clinical expertise, and confidentiality standards.
- It adopts NAIC data reporting requirements.
- It clarifies that in certain circumstances, the provider of record may initiate a member internal appeal on behalf of an enrollee.

Expedited External Appeals:

The most significant process change deals with the implementation of provisions for obtaining expedited external appeals. Through the external appeals program, members may apply for an expedited appeal if 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 his/her internal appeals before applying.

To qualify for an expedited appeal, the member must have his/her physician certify on the external appeal application form that 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 insurer/health care center/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 expedited appeal.

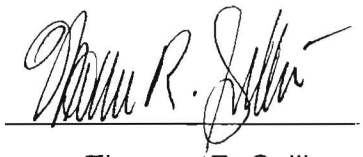
The review entity will review all requests and will be responsible for granting approval for the expedited appeal. If the expedited appeal is not accepted on an expedited basis, and the enrollee has not previously exhausted all internal appeals, the enrollee may resume the internal appeal process until all internal appeals are exhausted and then may file for a standard external appeal within 60 days following receipt of the final denial letter.

If all internal appeals were previously exhausted, the enrollee's rejected expedited appeal will automatically be eligible for consideration for standard appeal. The enrollee is not required to submit a new application.

Updated Materials:

The Insurance Department has updated the external appeal application form and the Consumer Guide to reflect the expedited external appeal process. The application is available on the Insurance Department's website under "FORMS" and the Consumer Guide is available under "PUBLICATIONS".

Please contact the Insurance Department Consumer Affairs Division at cid.ca@ct.gov or at 800-203-3447 with any questions.



Thomas R. Sullivan
Insurance Commissioner