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Reviewing Claim Decisions— Internal Appeals and External Review

Under Health Care Reform, health plans must comply with certain procedures regarding decisions to deny payment for treatment or services. When a claim is denied, an individual may request that the health insurance plan reconsider its decision—this review is called an "internal appeal." If the plan still denies payment after considering the appeal, the law permits the individual to have an outside third party decide whether to uphold or overturn the plan's decision—this is referred to as an "external review."

When a Claim Is Denied

In general, when a health plan denies payment for a treatment or service, it is required to notify the individual of:

- The reason the claim was denied;
- The individual's right to file an internal appeal;
- The right to request an external review if the internal appeal is unsuccessful; and
- The availability of a state Consumer Assistance Program that can help the individual file an appeal.

This explanation must be in writing and must be provided within 15 days when a claim is required to be filed before receipt of treatment or services (called "prior authorization"), within 30 days for medical services already received, or within 72 hours for urgent care cases.

Internal Appeals

An individual who disagrees with a decision made by the insurer not to cover or pay for medical care can request an appeal. When the plan receives this request, it is required to review its own decision to deny the payment or service. An individual generally has up to 180 days to file an internal appeal.

When an individual requests an internal appeal, the plan must provide its decision within:

- 30 days for denials of non-urgent care not yet received ("prior authorization" claims);
- 60 days for denials of services already received; and
- 72 hours (or less, depending on the medical situation) for denials of claims for urgent care (note that if the appeal concerns urgent care, it may be possible to have the internal appeal and external review take place at the same time).

What kinds of denials can be appealed?

An internal appeal generally may be filed when a plan will not provide or pay some or all of the cost for health care services. Examples of the reasons a plan might issue a denial include:

- The benefit that is used or sought is partially denied or is not a "covered service" (meaning the benefit is not offered under the health plan);
- The medical problem began before the individual joined the health plan;
- The individual received health services from a health provider or facility that is not in the plan's approved network (an "out-of network" provider);
- The requested service or treatment is "not medically necessary";

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- The requested service or treatment is an "experimental" or "investigative" treatment; or
- The individual is no longer enrolled or eligible to be enrolled in the health plan.

At the end of the internal appeals process, the insurer must provide the individual with a written decision. If the insurer continues to deny the service or payment, this written decision is called a "final internal adverse benefit determination." The final internal adverse benefit determination must tell the individual how to request an external review.

External Review

If the plan denies a request for payment or services after completing the internal appeal, the individual can ask for an independent external review to be conducted by a qualified outside third party that is not associated with the health plan. A standard external review is decided as soon as possible, but no later than 60 days after the receipt of a request.

A written request for an external appeal must be filed within 60 days of the date the health insurer or health plan sends the final internal adverse benefit determination (the final decision denying the services or claim for payment). Some states or plans may allow more time to file this request.

In urgent situations, an individual may request an external review even if he or she has not completed all of the health plan's internal appeals processes. The individual may file an internal appeal and an external review request at the same time. An urgent external review request may be made verbally.

What types of denials can go to external review?

- Denials that involve medical judgment (such as medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit) where the individual or his or her health care provider may disagree with the health insurance plan.
- Denials that involve a determination that a treatment is experimental or investigational.
- Rescissions of coverage, whereby a health insurance issuer takes steps to retroactively cancel or discontinue health insurance coverage going back to the date of enrollment, based on the insurer's claim that an individual gave false or incomplete information when he or she applied for coverage.

If the external reviewer overturns the insurer's denial, the insurer must give the payments or services requested in the claim.

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Steps for Appealing Health Plan Decisions

The following is a summary of the steps involved in the internal appeals and external review process

Step 1: A claim is filed (either by an individual or by the health care provider on his or her behalf	A claim is any request for benefits coverage. A claim to be reimbursed for the costs of treatment or services is usually filed after receipt of the treatment or services. Sometimes a claim is required to be filed before receipt of a treatment or service. This type of claim is called "prior authorization."
Step 2: The health plan denies the claim	If a health care plan denies all or part of a claim, it must notify the individual and explain why, in writing: » Within 15 days for prior authorization; » Within 30 days for medical services already received; and » Within 72 hours for urgent care cases. The insurer must explain the individual's right to appeal the decision and, if requested, must provide all the information about the plan's decision, such as the name of experts consulted. The insurer must print certain information on its denial notices, including the name of any Consumer Assistance Program available in the individual's state that can help the individual file an appeal.
Step 3: An internal appeal is filed	The individual files an appeal requesting that the insurer reconsider its decision to deny the claim. To file an internal appeal, the individual must: » Complete all forms required by the health insurer to request an internal appeal, or write to the insurer to provide notice that the individual is appealing the denial (the individual's name, claim number, and health insurance ID number should be included in this communication). » Submit any additional information that the individual wants the insurer to consider, such as a letter from the doctor. An appeal must be filed: » Within 180 days (6 months) of receiving notice that a claim was denied. » In writing, or, when the need for care is urgent, over the phone. Individuals with employer-sponsored coverage may be required to file two internal appeals before requesting an external review. For urgent health situations, individuals may ask for an external review request at the same time as the internal appeal request.

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Step 4: Issue is resolved or Insurer continues to deny the claim	The insurer must make a decision on the appeal: » Within 30 days for prior authorization; » Within 60 days for medical services already received; and » Within 72 hours in urgent care cases (or less, depending on the medical situation). An individual has the right to see and respond to all information used in the internal appeal decision.
Step 5: An external review is filed	If, at the end of the internal appeal process, the insurer continues to deny the requested benefits, the individual can seek an external review. The external review is conducted by an impartial expert who is not a direct employee of or related to the health insurer, who will provide an independent review of the denied claim. If the situation is urgent, an external review may be able to be filed at the same time as the internal appeal.
Step 6: External review either upholds or overturns the insurer's decision to deny payment	The insurer is required by law to accept the external reviewer's decision. A standard external review is decided as soon as possible, but no later than 60 days after the receipt of a request.