Internal Appeal/External Review FAQs

GENERAL INFORMATION

I disagree with my Health Plan Issuer's decision ……..WHAT CAN I DO?

You have the right, under Ohio law, to request the health plan issuer reconsider their decision, also known as an adverse benefit determination.

What is an adverse benefit determination?

An adverse benefit determination is a decision made by the health plan issuer to do any of the following:

- Deny, reduce or terminate a requested health care service or payment in whole or in part
- Not to issue health insurance coverage to you through an individual policy or non-employer group certificate
- To cancel or discontinue your health benefit plan coverage back to the original effective date as if the coverage never existed

Is there a minimum dollar amount that must be spent before I can request that the health plan issuer reconsider their decision?

No, your health plan issuer must review all adverse benefit determinations no matter how small the claim.

Do I have to pay if I request the health plan issuer reconsider their decision?

No, the health plan issuer is responsible for the cost of any internal appeal or external review

How do I request that the health plan issuer reconsider their decision?

You must first complete the health plan issuer's Internal Appeal process. If the health plan issuer continues to deny you services, payment or coverage at the end of the Internal Appeal process, you may then be eligible for their External Review process.

Who can request an internal appeal or external review?

You can request the appeal or review or you can name an authorized representative to do so.

Who can be my authorized representative?

Your authorized representative can be any of the following:

- Someone you have given express, written consent to represent you; or
- A person authorized by law to represent you; or
- When you are unable to give your consent, a family member or treating physician.

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INTERNAL APPEAL

What is an internal appeal?

Your health plan issuer will take another look at their decision to deny services, payment or coverage. You and your treating physician may have the opportunity to provide additional information to support your case.

How do I request an internal appeal?

You or your authorized representative must contact your health plan issuer to begin the INTERNAL APPEAL process. Your notice of adverse benefit determination should include the information necessary to file your request. Your policy or certificate provides information on this process, or you can call the health plan issuer's customer service department for instructions. Your health plan issuer will review the decision and any additional information submitted to support your case.

What if my situation is urgent?

You may be eligible for an expedited internal appeal of the health plan issuer's decision when any of the following conditions apply:

- Your health or life may be in serious jeopardy or you may not be able to regain maximum function if treatment is delayed while you wait for a decision
- You experience pain that cannot be adequately controlled while you wait for a decision

If your pain cannot be adequately controlled your treating physician must certify that. Also, your physician may certify the seriousness of your illness.

Am I eligible for a concurrent expedited internal appeal and expedited external review?

You may be eligible to have your expedited internal appeal and expedited external review of the health plan issuer's decision occur at the same time when your treating physician certifies either of the following conditions:

- Your medical condition could seriously jeopardize your life, health or your ability to regain maximum function if treated after the time frame of an expedited internal appeal
- In the case of an experimental or investigational treatment, the recommended health care service or treatment would be less effective if not started right away

You must contact your health plan issuer if you wish to request a concurrent expedited internal appeal and expedited external review.

When will I have a decision regarding my request for internal appeal?

For individual and non-employer group coverage, the internal appeal process should take no longer than 30 days from the date when a complete appeal *(all information necessary to review the appeal)* is received by the health plan issuer. For employer group coverage, the internal appeal process should take no longer than 30 days from the date when a complete appeal is received by the health plan issuer for each level of internal appeal (there can be no more than two levels). When your situation is urgent and the health plan issuer is performing an expedited internal appeal, you should receive your decision as quickly as your medical condition requires but no later than 72 hours after your request is received by the health plan issuer. If the health plan issuer agrees to reverse its decision, the service or payment you

requested is provided to you. If the health plan issuer continues to deny the services or payment, a final adverse benefit determination will be issued. You can then file a request for an EXTERNAL REVIEW.

EXTERNAL REVIEW

What is an external review?

An external review is performed by an outside organization that is not affiliated with the health plan issuer. When the internal appeal process is complete and the health plan issuer continues to deny benefits the health plan issuer will issue a final adverse benefit determination. When the final adverse benefit determination concerns a decision that is based on medical judgment or an experimental or investigational treatment, the review is performed by an Independent Review Organization (IRO). If the final adverse benefit determination is based on a contractual issue that does not involve medical judgment the review will be performed by the Ohio Department of Insurance. In the event your medical condition did not meet the definition of an "emergency" the requested review will be performed by an IRO. If the IRO upholds the health plan issuer's decision, you can request the Ohio Department of Insurance make a determination of whether the condition was an emergency based on the prudent layperson standard.

Do I have to complete the internal appeal process before I can request an external review?

You must exhaust the health plan issuer's internal appeal process before you can seek an external review except in the following instances:

- the health plan issuer agrees to waive the exhaustion requirement
- you did not receive a written confirmation of the health plan issuer's internal appeal decision within the required time frame
- the health plan issuer fails to meet all requirements of the internal appeal process unless the failure:
    - was de minimis
    - does not cause or is not likely to cause prejudice or harm to you
    - was for good cause and beyond the control of the health plan issuer
    - is not reflective of a pattern or practice of non-compliance
- you request an expedited external review at the same time as an expedited internal review (see above discussion of when concurrent internal appeal external and review is appropriate)

How do I request an external review?

You or your authorized representative must contact your health plan issuer to begin the EXTERNAL REVIEW process. Your notice of final adverse benefit determination received from the health plan issuer should list the information necessary to file your request. The request must be in writing and can be sent by U.S. Mail, email or fax. If your situation is urgent (please see "What if my situation is urgent" below), you can request your review over the phone. You must request the external review within 180 days of the date of the final adverse benefit determination. Your policy or certificate provides information on this process, or you can call the health plan issuer's customer service department for instructions. If your situation is NOT urgent, your health plan issuer will let you know in writing that you have 10 business days to submit additional information to support your case. The additional information should be submitted directly to the entity performing the review, either the IRO or the Ohio Department of Insurance.

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What if my situation is urgent?

You may be eligible for an expedited external review of the health plan issuer's decision when any of the following conditions apply:

- Your health or life may be in serious jeopardy or you may not be able to regain maximum function if treatment is delayed while you wait for a decision
- The health plan issuer's decision concerns an admission, continued hospital stay, availability of care or health care service for which you received emergency services but have not yet been discharged from a facility
- Your treating physician believes that the experimental or investigational treatment requested would be less effective if not started right away

Your treating physician must certify in writing that any of the conditions listed above apply in your case.

When will I have a decision regarding my request for external review?

If your situation is NOT urgent, the external review process should take no longer than 30 days from when a complete request *(all information necessary to review the decision)* for external review is received by the health plan issuer. When your situation is urgent, you should receive your decision as quickly as your medical condition requires but no later than 72 hours after your request is received by the health plan issuer. If the IRO agrees with you and tells the health plan issuer to reverse its decision, the service, payment or coverage you requested will be provided to you. If the IRO upholds the denial and the health plan issuer continues to deny the service, payment or coverage, the external review process is complete. You have the right to file a private lawsuit and may request another external review of the decision only if new medical or scientific evidence is available and submitted to the health plan issuer.

How will I be informed of the decision?

Once a decision is made, you will be notified in writing by the IRO or in the case of a contractual review, the Department of Insurance. In urgent care situations you may be notified by telephone, fax or email and will receive written confirmation within 48 hours of the decision.