Your Insurer Denies a Claim or Coverage. What Can You Do?

Appealing a Denial From Your Health Benefit Plan

Expanded Version

Table of Contents

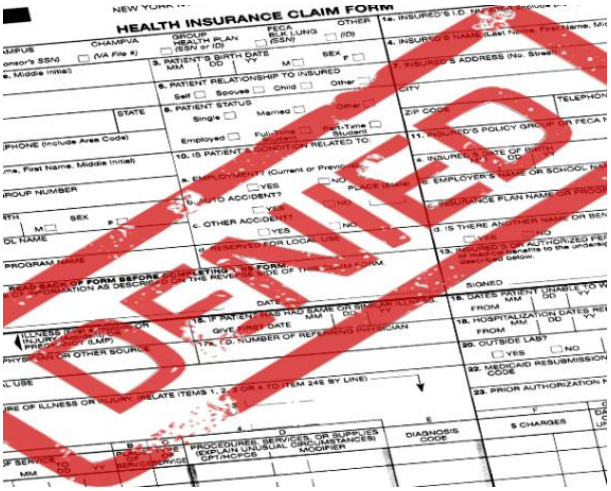
Know Why Your Insurer Denied Coverage

Consumer's Right to Appeal Health Benefit Plan Denials

Consumers have the right to know why an insurer denied a claim or terminated their coverage. They have the right to an internal appeal process and to an additional impartial review if needed. Urgent medical appeals can be requested on an expedited basis**.**

An adverse benefit determination (ABD) is a denial, reduction, termination or failure to provide or make payment (in whole or in part) for a benefit. There are different types of ABDs based on a determination that the benefit (i.e., service, treatment, drug or device) is:

- Not medically necessary.
- Experimental or investigational.
- Not covered or is excluded by the health plan.
- Reduced due to the insured's failure to follow the plan delivery rules (e.g., insured did not obtain pre-authorization or did not use an in-network provider).
- Denied because the individual(s) is/are not eligible to participate in the plan.
- Denied due to a rescission of coverage (cancellation of the policy back to the effective date, leaving the consumer responsible for all medical bills, including those already paid by the insurance company) based on fraud or intentional misrepresentation.



Appeals for denial of ABDs must first go through the internal appeal process with the insurer before seeking an additional impartial review.
(Simultaneous internal/external appeals are allowed in certain circumstances. See expedited appeals on page 3.)

Complete Your Internal Appeal First!

Internal Appeals

When a health benefit plan issues an ABD and you disagree with the insurer's conclusion, you or an authorized person (including your provider) acting on your behalf have the right to appeal the denial.

The internal appeal process begins when you or your authorized representative appeals a denial by the insurer. It is done by writing to your insurer within 60 days (or longer time designated by plan) from receipt of your denial. Your insurer is required to respond in writing within 30 days of receiving your appeal or within 72 hours if an expedited appeal is requested by the treating physician. (See your health benefit plan document for details specific to your plan.)

If upon completion of the internal appeal process, your insurer continues to uphold their denial, there are options for an additional impartial review depending on the reason for the ABD, such as the service, treatment, drug or device is:

1. Not medically necessary or it is experimental/investigational.
2. Limited or excluded in your contract (i.e., plan document).
3. Denied because the plan delivery rules were not followed or other miscellaneous reason(s) or grievance(s).

Get an Impartial Review

How to Appeal to a Neutral Entity

To initiate an additional impartial review for an ABD when:

1. Benefit is determined as not medically necessary/experimental or investigational.

If the denial is based on the insurer's decision that a benefit is not medically necessary or as being an experimental and/or investigational treatment, **the appeal for the additional impartial medical review is sent to your insurer.**

- You or your authorized representative acting on your behalf (with your written permission) may submit a request in writing to the insurer asking for an external review.*
- The appeal must be made to your insurer within four months of receipt of your upheld denial letter.
- You must sign a release of medical information form, provided to you by your insurer with the denial letter, authorizing the independent review entity (IRE) to obtain all necessary medical records from your insurer and provider(s).
- Your insurer will notify you when the external impartial, medical review is assigned to the IRE.

***External Review:**
An external review is an assessment of an ABD for medical necessity conducted by an IRE not associated with your insurer. There are two types of external reviews:

a. A non-expedited (non-emergency) review shall not exceed 45 days.
b. An expedited external review shall not exceed 72 hours.

An IRE is a company (not associated with your insurer) certified by the Kentucky Department of Insurance to perform external reviews. The IRE uses health care professionals and insurance coverage specialists to review decisions and make determinations as to whether the request for coverage was medically necessary, appropriate and covered under the plan.

Expedited Appeal

An appeal shall be considered an expedited appeal and can be conducted simultaneously with an internal appeal if at least one of these applies:

- You are hospitalized.
- Your treating physician determines it is urgent care.
- The decision to deny coverage could seriously jeopardize the life, health or the ability to regain maximum function.
- If in the opinion of your treating physician, who has knowledge of your medical condition, you would be subjected to severe pain that cannot be adequately managed without the care that is the subject of the review.
- The requested service is experimental or investigational and your physician certifies in writing that the service will be significantly less effective if not initiated promptly.

The IRE's decision is binding on you and your insurer and the IRE may bill you a fee of $25, unless their decision is in your favor.

2. Benefit determined as limited or excluded in your health benefit plan.

If the denial is based on a benefit limitation or exclusion in your plan you may request an impartial review by the Department of Insurance after completing the internal appeal process with your insurer.

- Submit your request in writing to the **Kentucky Department of Insurance, Health Policy Utilization Review Branch, Attention: Coverage Denial Coordinator, P.O. Box 517, Frankfort, KY 40602.**
- Enclose a copy of the denial letter from your health benefit plan.
- State the reason you believe coverage should be provided.

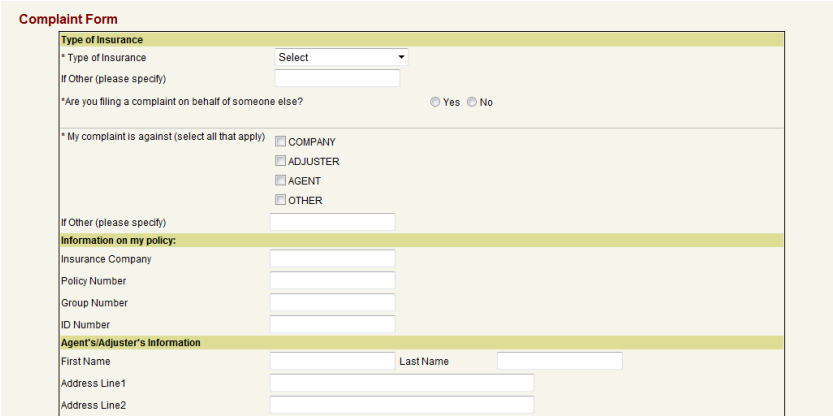
The Coverage Denial Coordinator will request information from your insurer and make a determination that the service, treatment, drug or device meets one of the following:

- Is specifically excluded under your plan and the insurer's denial was correct.
- Is covered and will instruct your insurer to pay the claim.
- Requires the resolution of a medical issue and will instruct your insurer to either cover the claim or give you the opportunity to request an external review.

3. Plan delivery rules were not followed or other reason for receiving an ABD.

Plan delivery rules are requirements or specific procedures set forth in your health benefit document that must be followed to obtain maximum benefits (i.e., getting a pre-authorization, using an in-network provider). Other grievances can involve such events as your plan being canceled or rescinded.

If the ABD is a denial issued due to the member's failure to follow the plan delivery rules, or you have a general complaint, you may submit an appeal/complaint in writing to the **Kentucky Department of Insurance, Division of Consumer Protection, P.O. Box 517, Frankfort, KY 40602** or you can fill out an Online Complaint Form. State your reason(s) for appealing the ABD and submit copies of any documentation that supports your position.


Complaint Form

Type of Insurance

* Type of Insurance: Select

If Other (please specify)

*Are you filing a complaint on behalf of someone else? Yes No

* My complaint is against (select all that apply): COMPANY, ADJUSTER, AGENT, OTHER

If Other (please specify)

Information on my policy:

Insurance Company

Policy Number

Group Number

ID Number

Agent's/Adjuster's Information

First Name Last Name

Address Line1

Address Line2

Do These Rights Apply to Me?

P**lease Note:** This is general information. Consumers should refer to their plan documents for specifics. These rights **do not** apply if the insured is covered by certain policies including Medicare supplements, student health plans connected with a university, or employer self-funded plans. **These rights pertain to those covered under fully insured plans issued in Kentucky**.

Where Do I Call For Help?

If you have any questions regarding any of these types of appeals, you may contact the **Division of Consumer Protection**:

Kentucky Department of Insurance
Division of Consumer Protection
P.O. Box 517
Frankfort, KY 40602

Internet: http://insurance.ky.gov/Home.aspx?Div_ID=4

Phone: **800-595-6053** (Kentucky residents only) or **502-564-6034**
(ask to speak to a Consumer Complaint Investigator)