What you should know about...
Health insurance appeals

Individuals who are enrolled in health benefit plans have expanded appeal rights under KRS 304.17A-617. You have the right to appeal an insurer's decision to deny access to a treatment, service, drug or device. **Note: These rights do not apply if you are covered by certain policies including Medicare supplements, student health plans connected with a university or employer self-funded plans.**

What can you do if your health benefit plan refuses to cover a service?
You have the right to appeal. For example, your physician prescribes a surgical procedure and your insurer refuses to pay for it. You can appeal the decision. An appeal is a formal request that the decision be reviewed and reversed. There are three kinds of appeals:

- *Internal appeal* - Review of the denial by the insurance company.
- *Coverage denial review* - Review of the denial by the Department of Insurance.
- *External review* - Review of the denial by an independent review entity not associated with the insurer.

Who can initiate an appeal under the law?
A person covered by a health benefit plan, a health-care provider, or an individual authorized to act on the covered person's behalf can request an appeal.

How do you begin the appeal process?
Read the letter or notice sent by the insurer to find out why your request was denied and what you need to do to appeal the decision. (The box above lists what must be included in a denial letter.) If you have questions, call the contact person listed in the letter. Have your policy, health insurance card and Social Security number in hand when you make the call. It will be helpful if you know the exact diagnosis and the treatment you need in medical terms.

Information your insurer must provide

The letter or notice from the insurer must contain:

- ✓ A statement giving specific medical and scientific reasons for the denial or identifying the provision in the benefits schedule or exclusions that demonstrate that coverage is not available.
- ✓ The state of licensure, medical license number, and the title of the person making the decision.
- ✓ Unless services have already taken place, a description of other alternative benefits, services or supplies covered by the health benefit plan, if any.
- ✓ Instructions for initiating an internal appeal of the denial including whether the appeal has to be in writing, time limits, schedules for filing appeals, and the position and phone number of a contact person for further information.

Important terms you should know

Here are two terms that you need to know when filing an appeal:

- *Coverage denial* – The insurer contends that a service, treatment, drug or device is not covered by the person's health benefit plan and sends the covered person a notice of coverage denial.
- *Adverse determination* – The insurer determines a service, treatment, drug or device is "not medically necessary or appropriate, experimental or investigational" and denies, reduces or terminates coverage of the service, treatment, drug or device.

Internal appeals

The process begins when the covered person receives an adverse determination ***or*** a notice of coverage denial; or the insurer fails to make a determination within a certain time, or the insurer fails to send a notice. Then:

1. The covered person, a health care provider or an authorized person requests an internal review (appeal) by the insurer. He or she may ask that a specialist conduct the review.

2. Insurers or their representatives must make a decision within 30 days of receipt of the appeal request -- or within three days if it's an expedited (emergency) appeal, which is available if you are hospitalized or your treating provider believes that waiting for a standard internal appeal decision would seriously jeopardize your health -- and inform the covered person that:

   (a) Payment is approved or
   (b) Payment is denied. The insurer must provide information on the reasons for this decision.

Coverage denial review (contract issue)

If the issue is *coverage denial* and an internal review by the insurance company has been completed, the covered person or the authorized person can ask for a review by the Department of Insurance. At that time:

1. A written request for review is submitted by the covered person or an authorized person to the Department of Insurance, **Attn: Coverage Denial Review Coordinator**, P.O. Box 517, Frankfort, KY 40602-0517.

2. The Department will review the request, require the company to respond within 10 business days, and make a determination that:

   (a) The coverage in question is limited or excluded by the health plan, or
   (b) The coverage *is not* limited or excluded and the company must pay for the service or allow the person to have an external review.

External review (medical necessity issue)

When can you ask for an external review?
If paying the medical bill yourself will cost you $100 or more and your internal appeal has been completed, you can request an external review. The request can be made by you or someone acting on your behalf with your written permission. The request must be filed within 60 days of receiving the insurer's final denial letter. The steps are:

1. You or an authorized person submits a request for an external review to your insurer, and gives written consent for disclosure of medical records to the independent review entity (IRE).

What is an IRE?

An independent review entity (IRE) uses health care professionals and insurance coverage specialists to review decisions and determine if a service is medically necessary, appropriate and covered. An IRE must be certified by the Kentucky Department of Insurance to ensure that the entity is qualified and able to conduct external reviews in a timely matter.

Specific measures are taken to ensure that no conflict of interest exists and that an IRE is independent and free of any alliance with any of the parties involved.

The IRE must consider information submitted by the insurer, the covered person and the health care provider plus any relevant medical research or findings.

Written complaints concerning an IRE's conduct of an external review may be submitted to the Department of Insurance.

2. If your insurer refuses to grant you an external review, you may file a complaint with the Kentucky Department of Insurance. Within five days, the Department of Insurance will make a decision about whether you are entitled to an external review.

3. An IRE will be assigned to conduct the external review in accordance with Kentucky insurance laws.

4. The insurer must pay for the review; however, you will be billed by the IRE for a $25 filing fee. This fee can be waived if you can show that payment will cause financial hardship as defined by 806 KAR 17:290. The fee will be refunded or waived if the IRE finds in your favor.

5. The time frame an IRE has to make a determination:

   - Expedited (emergency) external reviews must be completed within 24 hours of receipt of all information required from the insurer unless you or your representative and the insurer agree to a 24-hour extension.
   - Nonexpedited (nonemergency) external reviews must be completed within 21 days of receipt of all information required from the insurer unless you or your representative and the insurer agree to a 14-day extension.

Financial hardship

With regard to the waiving of the filing fee for an external review, financial hardship is defined by 806 KAR 17:290, which states that the following shall be accepted by the independent review entity as evidence of financial hardship:

a. Gross income of the covered person below 200 percent of the federal poverty level based upon family size as shown by a federal income tax return for the previous year; or

b. The covered person's participation in one (1) of the following programs:
   - National Prescription Drug Patient Assistance;
   - Kentucky Transitional Assistance;
   - Medicaid; or
   - Unemployment Insurance

What happens next?

If the IRE decides in your favor, the insurance company must pay for the service, treatment, drug or device. If the external review decision *is not* in your favor, you have a right to file a civil lawsuit.

If you have additional questions about health insurance appeals or other issues, you may contact the Kentucky Department of Insurance, Consumer Protection and Education Division through the Web site (doi.ppr.ky.gov) or by phone. The office's toll-free number is 800-595-6053, and the TDD number for the deaf/hard of hearing is 800-648-6056.

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