IDAHO EXTERNAL REVIEW FAQ

What is an external review?

External review is a process where expert independent medical professionals review specific medical decisions made by health carriers. The Idaho Department of Insurance (DOI) administers an external review program that enables Idaho consumers to request an impartial review of medical decisions within certain guidelines under the Idaho Insurance Code. Chapter 59 of Title 41, the Idaho Health Carrier External Review Act, applies to certain health plans issued or renewed on or after January 1, 2010. This act explains the external review process in detail. Idaho consumers have the right to an external review of a health claim denial if the health carrier denied the claim for these reasons:

- The medical necessity, appropriateness, health care setting, level of care or effectiveness of the service or supply; or
- The service or supply is investigational.

External review may not be used for a health carrier decision based on a coverage issue, such as eligibility for coverage or limited payment on a covered expense. Only decisions regarding a disputed health care service or supply, as related to the practice of medicine, that do not involve a coverage issue are qualified for external review.

When can I request an external review?

As a covered person, you may request an external review of a health carrier's final decision to deny a service or supply. You must first exhaust all levels of internal appeals or grievances with your health carrier before you can apply for an external review. "Exhaust all levels" includes:

- Complete the health carrier's internal process as explained in your policy, coverage booklet or Explanation of Benefits and receive a final denial notice from the health carrier; or
- Unless you agreed to a delay with the health carrier, you have not received a decision on your appeal from the health carrier within 35 days of a standard appeal or 3 business days on an urgent care request; or
- The health carrier agrees to waive the appeal exhaustion requirement, or has failed to provide a timely, full and fair opportunity for you to take advantage of its internal grievance procedures; or
- The request is an urgent care request and you are applying for an expedited external review with the Idaho Department of Insurance (DOI) at the same time as applying for an expedited internal review with the health carrier.

No later than four months from the date of the health carrier's final denial or you have exhausted all levels of appeal, you may submit a written request for an external review to the DOI. You must use Idaho's External Review Request Form.

How do I request an external review from the Idaho Department of Insurance?

You may request an external review if you disagree with the health carrier's final decision that a service or supply is not medically necessary or is investigational. Your health carrier is required to send you a "Notice of Your Right to an Independent External Review" with its final denial letter.

To apply for an external review, you must complete and send the following to the DOI:

- External Review Request Form
    - If you want to designate someone else to represent you in the external review process, be sure to complete the "Appointment of Authorized Representative" section of the request form.
- A photocopy of your insurance ID card or other evidence showing you are insured with the health carrier named in your request
- A copy of the final determination letter from your health carrier
- A copy of your certificate of coverage or policy benefit booklet which lists the benefits under your health plan
- For urgent care requests for an expedited review, the Certification by Treating Health Care Provider included with the External Review Request Form.

Send all paperwork to:
Idaho Department of Insurance
ATTN: External Review
700 W State St, 3rd Floor
PO Box 83720
Boise ID 83720-0043

Call the DOI at 208-334-4250 (or 1-800-721-3272 toll-free in Idaho) if you need help in completing your request. You may also email questions to Consumer Affairs.

For an expedited review of an urgent care request, call the DOI before sending your paperwork. We will give you instructions on the quickest way to send your request. See "What if I need a faster review for an urgent care request?" for more information.
Can someone else request an external review for me?

In the External Review Request Form sent to the DOI, a covered person may designate someone else to act as the covered person's representative for an external review, including a health care provider.

What issues are eligible for external review?

You may request an external review of a health carrier's final decision to deny claims for these reasons:

- The medical necessity, appropriateness, health care setting, level of care or effectiveness of the service or supply; or
- The service or supply is investigational.

External review may not be used for a health carrier decision based on a coverage issue, such as eligibility for coverage or limited payment on a covered expense. Only decisions regarding a disputed health care service or supply, as related to the practice of medicine, that do not involve a coverage issue are qualified for external review.

What issues are not eligible for an external review?

All other health carrier decisions that do not involve medical necessity or investigational services or supplies are not eligible for external review. These decisions may include, but are not limited to:

- Claims denied because the service or treatment is not covered under the insurance plan. Denials due to coverage issues or other related underwriting issues do not qualify for external review.
- Legal interpretations of insurance plan language, provisions and terms do not qualify for external review.
- Bad faith allegations and other demands for extra payments under the insurance plan do not qualify for external review.
- Certain types of insurance plans, such as supplemental or limited benefit plans, long-term care, Medicare, Medicaid and the Federal Employees Health Benefit Program do not qualify for external review. See Idaho Code Section 41-5904 for a complete list of plan types that do not qualify.
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What types of coverage qualify and do not qualify for external review?

Coverages that qualify for external review include:

- Most individual and fully-insured group health benefit plans that provide coverage and pay for costs of hospital, medical and surgical services
- Self-funded health care plans registered with the DOI
- The Idaho Individual High Risk Reinsurance Pool Plans

Some coverages that do not qualify for external review include:

- Supplemental or limited benefit plans
- Workers' Compensation
- Medicare Advantage or Medicare supplement plans
- Medicaid
- Federal Employees Health Benefits Program
- Single employer self-funded employee benefit plans subject to ERISA, unless the plan administrator has sent a written request to the DOI to opt in to Idaho's external review process.

See Idaho Code Section 41-5904 for a complete list of plan types that do not qualify.

How does the external review program work?

The First Step – Notice and Application. You may request an external review if you disagree with the health carrier's final decision. Your health carrier is required to send you a "Notice of Your Right to an Independent External Review" with its final denial letter.
To apply for an external review, you must complete and send the following to the DOI:

- External Review Request Form
    - If you want to designate someone else to represent you in the external review process, be sure to complete the "Appointment of Authorized Representative" section of the request form.
- A photocopy of your insurance ID card or other evidence showing you are insured with the health carrier named in your request
- A copy of the final determination letter from your health carrier

- For urgent care requests for an expedited review, the Certification by Treating Health Care Provider included with the External Review Request Form.

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ATTN: External Review
700 W State St, 3rd Floor
PO Box 83720
Boise ID 83720-0043

Call the DOI at 208-334-4250 (or 1-800-721-3272 toll-free in Idaho) if you need help in completing your request.

For an expedited review of an urgent care request, call the DOI before sending your paperwork. We will give you instructions on the quickest way to send your request. See "What if I need a faster review for an urgent care request?" below for more information.

The Second Step – Eligibility for a Standard Request. When the DOI receives your completed request for external review, the DOI will send that information to your health carrier within seven days of receipt. Your health carrier will review your request within 14 days of receipt. Your health carrier will notify the DOI and you in writing within five business days if your request is complete and eligible, or if the request needs additional information or if the request is not eligible. If your health carrier determines your request is not eligible, you may appeal that decision to the DOI.

The Third Step – The Review Process. The DOI will assign your request to an IRO within seven days of notice from your health carrier that your request is eligible and complete. The DOI will send you and the carrier written notice of the IRO assigned to your request. Your health carrier has 14 days to send the IRO all information regarding your request.

The Fourth Step – The Determination. The IRO must make a decision within 42 days of receipt of your request and notify you, the health carrier and the DOI of the results of that decision. That written notice must include the principal reason(s) for IRO's decision, the important documents reviewed and the findings that are relevant to your request.

The Fifth Step – Implementation. If the IRO determination overturns the health carrier's decision, the health carrier must approve benefits or coverage for the supply or service as soon as reasonably practicable, but not later than one business day after receiving the IRO's determination notice.

See Idaho Code Section 41-5908 for the complete standard review process.

What if I need a faster review for an urgent care request?

The First Step – Notice and Application. You or your authorized representative may request an expedited review for an "urgent care request" once you have exhausted your health carrier's internal grievance process. You may also file an urgent care request for an expedited external

review with the DOI at the same time as applying for an expedited internal review with the health carrier. Your health carrier is required to send you a "Notice of Your Right to an Independent External Review" with its final denial letter.

An "urgent care request" is defined in Idaho Code Section 41-5903(39) to mean a claim relating to an admission, availability of care, continued stay or health care service for which a covered person received emergency services but has not been discharged from a facility or, any pre-service or concurrent care claim for medical care or treatment for which application of the time periods for making a regular external review determination:

1. Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function;
2. In the opinion of the treating health care professional with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the disputed care or treatment; or
3. The treatment would be significantly less effective if not promptly initiated.

To apply for an expedited external review, you must complete and send the following to the DOI:

- External Review Request Form
    - If you want to designate someone else to represent you in the external review process, be sure to complete the "Appointment of Authorized Representative" section of the request form.
- A photocopy of your insurance ID card or other evidence showing you are insured with the health carrier named in your request
- A copy of the final determination letter from your health carrier
- A copy of your certificate of coverage or policy benefit booklet which lists the benefits under your health plan
- The Certification by Treating Health Care Provider included with the External Review Request Form

For an expedited review of an urgent care request, call the DOI at 208-334-4250 (or 1-800-721-3272 toll-free in Idaho) before sending your paperwork. We will give you instructions on the quickest way to send your request.

Your expedited review can be personally delivered to:
Idaho Department of Insurance
ATTN: External Review
700 W State St, 3rd Floor
PO Box 83720
Boise ID 83720-0043

The Second Step – Eligibility for an Expedited Request. When the DOI receives your completed request for external review, the DOI will immediately send that information to your health carrier. Your health carrier will review your request within two business days of receipt. Your health carrier will notify the DOI and you in writing within one business day if your request is complete and eligible, or if the request needs additional information or if the request is not eligible. If your health carrier determines your request is not eligible, you may appeal that decision to the DOI.

The Third Step – The Review Process. The DOI will assign your request to an IRO immediately after notice from your health carrier that your request is eligible and complete. The DOI will send you and the carrier notice of the IRO assigned to your request. Your health carrier will send the IRO all information regarding your request by the fastest possible method.

The Fourth Step – The Determination. The IRO must make a decision within 72 hours of receipt of your request and notify you, the health carrier and the DOI of the results of that decision. The IRO must provide written confirmation within 48 hours of its decision, including the principal reason(s) for IRO's decision, the important documents reviewed and the findings that are relevant to your request.

The Fifth Step – Implementation. If the IRO determination overturns the health carrier's decision, the health carrier must notify you and the DOI of its intent to pay benefits as soon as reasonably practicable, but not later than one business day of receipt of the IRO's determination notice.

See Idaho Code Section 41-5909 for the complete expedited external review process.

What does an independent review organization look at to make a decision?

The IRO makes a decision on an external review request about the denial of medical necessity or investigational services or supplies by reviewing your specific medical needs and several other factors, including:

- Your completed External Review Request Form and other documents you submitted
- Your medical records
- The attending health care professional's recommendation
- Consulting reports from appropriate health care professionals and other documents submitted by you or the health carrier
- The terms and conditions of your health benefit plan
- The most appropriate practice guidelines, based on evidence-based standards or as may be developed by the federal government, national or professional medical societies, boards and associations
- The health carrier's internal guidelines and medical policies
- Medical or scientific evidence, as defined in Idaho Code Section 41-5903(32)
- Expert opinion

How much does an external review cost?

The cost of an external review is paid completely by your health carrier after the IRO makes its decision on your external review request. You do not have to pay any fee or charge for this service.

Is the independent review organization's decision final?

If your health plan is subject to federal ERISA laws (generally, any plan offered through an employer to its employees), the decision made by the IRO will be final and binding on your health carrier. You may have additional review rights provided under federal ERISA laws.

For other types of health plans, if you request an independent external review of your claim, the decision made by the IRO will be binding and final for you and the health carrier. You will have

no further right to have your claim reviewed after the IRO issues its final decision. If you choose not to use the external review process, other options for resolving a disputed claim may include mediation, arbitration, or filing an action in court.

See Idaho Code Section 41-5910 for a complete explanation of the binding nature of the external review decision.

Are medical records kept confidential in the external review process?

All medical records are confidential throughout the external review process. The confidentiality of medical records and review materials is subject to all applicable state and federal laws.

Health Insurance Terms and Phrases:

Covered person means you or an insured member of your family covered under the health carrier's health benefit plan. The term may also include a covered person's authorized representative.

DOI means the Idaho Department of Insurance

Health carrier means an entity subject to Idaho insurance laws and regulations or subject to the jurisdiction of the director of the DOI that contracts or offers to contract to provide deliver, arrange for, pay for or reimburse any of the costs of health care services. Health carrier includes a disability insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health care services.

IRO means an independent review organization that conducts independent external reviews of final adverse benefit determinations.

Investigational means the term as defined in your health benefit plan, or if not defined in your plan, as defined in Idaho Code Section 41-5903(30).

Medically necessary or **medical necessity** means the term as defined in your health benefit plan, or if not defined in your plan, as defined in Idaho Code Section 41-5903(31).

Urgent care request is defined in Idaho Code Section 41-5903(39) to mean a claim relating to an admission, availability of care, continued stay or health care service for which the covered person received emergency services but has not been discharged from a facility, or any pre-service or concurrent care claim for medical care or treatment for which application of the time periods for making a regular external review determination:

1. Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function;
2. In the opinion of the treating health care professional with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the disputed care or treatment; or
3. The treatment would be significantly less effective if not promptly initiated.