NC Department of Insurance

HAVE YOU HAD A HEALTH CLAIM DENIED?

What is an External Review?
External Review is a free service to help you if your insurance company has denied coverage of a medically necessary treatment. It is the last option for contesting an insurance company's denial outside of the legal system and, in most cases, can be used after your attempts to gain coverage through the insurer's own appeal process have been made but were unsuccessful.

External Review is administered through the Department of Insurance Health Insurance Smart NC (Smart NC) and is performed by medical professionals who have no affiliation with you, your health care providers or your insurance company. This allows them to be unbiased when reviewing your case.

Many people have taken advantage of this service since Smart NC began. Close to one-half of all the people who received an external review ended up receiving coverage for the service that had originally been denied. External review has resulted in over $12 million in services being paid for what would have been turned down otherwise.

Who Can Request an External Review?
You, or any person that you authorize to act on your behalf (including your doctor), can request an external review. If you choose to have someone represent you, you must consent to such representation by signing the Appointment of Authorized Representative area on the external review request form.
External review is available to consumers who:

- participate in a health insurance plan that provides or performs "utilization review" of requested medical services,
- are covered under the North Carolina State Health Plan, or
- are covered under the North Carolina High Risk Pool (Inclusive Health).

Insurance companies are required to notify you of your right to external review any time a denial is made that may be eligible for external review.

You will not be able to request an external review if:

- Your health insurance contract is written in a state other than North Carolina. The state where the health insurance contract was written may offer similar services.
- Your health insurance is provided through a self-funded employer health plan. Your local U.S. Department of Labor office may be able to provide you with additional information or resources.
- Your health insurance is Medicaid, Medicare or a Medicare Supplement. The Department of Medical Assistance (for Medicaid) or the Centers for Medicare and Medicaid Services (CMS) (for Medicare) may be able to offer additional information.
- Your insurance is specifically for dental, vision, long-term care, disability, any specified disease or for payments made under homeowners or automobile insurance.
- Your insurance is for Worker's Compensation. The North Carolina Industrial Commission may be able to offer additional information.

What Do I Need to Do?
If you want to request an external review, complete the External Review Request Form and submit it to Smart NC within 120 days of the date on the denial letter sent by your insurance company. The interactive form available online allows you to type directly into the form to complete most of the information, and is best viewed in AdobeReader. It is then necessary to print the form and sign in the required areas. It can also be printed and filled in by hand. It is important to fully complete this form and sign the form before submitting the request to Smart NC. Instructions on the form give detailed explanations of the information that is required. Once you have completed the form, submit to Smart NC:

Insurance Benefit System Administrators I Attn: Internal Claim Reviews I PO Box 2917 I Shawnee Mission, KS 66201-1317

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- the Request Form,
- medical records, radiology reports, test results specific to the denial,
- a copy of your insurance card,
- a copy of the final denial letter from the insurer, and
- a description of the disagreement.

There is no fee for this service, and Smart NC staff members are available to assist you further if you have any questions about the form.

What Happens Next?
After Smart NC receives your request, staff will contact your insurance company for additional information that is needed to perform a review to determine if your request is eligible.

Generally, you will be eligible for a standard external review if:

- You have submitted your request within 120 days from the date on the final denial letter.
- Your request relates to a health plan that is subject to the external review law (i.e., not self-funded health plan, Medicare, Medicaid, Medicare supplement, dental, visions, long-term care, specified disease, workers compensation or auto).
- Your insurance company denied coverage on the basis that the services are not medically necessary or are cosmetic or experimental in nature. Other types of denials such as those made because services were not preauthorized, services were received "out of network" (unless there is disagreement over whether it is medically necessary to go out of network) or are explicitly excluded in your policy are not eligible for an external review. Additionally, external review cannot settle reimbursement or payment issues related to a covered service.
- You were covered under the policy at the time the service was performed.
- The service reasonably appears to be a covered benefit. If your policy excludes the specific service, it is not a covered benefit.
- In most cases, you have already completed the insurer's appeal process. For medically urgent cases requiring an immediate decision, you may not need to complete the appeal process. Smart NC offers assistance to consumers in filing medical appeals and grievances with their healthplans if you desire help with this.

Smart NC wants to assure that consumers have the best chance of a successful request for external review. Because we feel that it is important for you to understand the eligibility requirements, there is additional information available relating to this in the Frequently Asked Questions, or feel free to contact the Program for further information.

Smart NC will determine if your request is eligible for external review. You will receive a letter from the Program notifying you of that decision. If the request is not accepted, the letter will state the specific reason why your request was not determined to be eligible. If the request is accepted, you will be given further information regarding your rights and responsibilities, and the name of the Independent Review Organization (IRO) that will receive your request for the independent medical review to be completed.

When a request is accepted for external review, North Carolina law requires the insurance company to send all information that was used to make its denial decision for the services being requested to the IRO and to the covered person or authorized representative who made the request for external review on behalf of the covered person, within seven days of the notice that the request was accepted. You will have an opportunity to provide any additional information that you would like the reviewer to consider during this same seven day period. The reviewer, a medical professional who is an expert in the treatment of the injury, illness or medical condition that is the subject of the review, will review the information and make a decision about the services. If the medical professional agrees that the services should have been covered, the insurance company will be required to pay for the services. This decision is binding on the company, which means the company will have to pay. If you lose your case, however, you may have other remedies available under State or Federal law including lawsuits.

Can I Be Present at the Review?
No, the review is not structured as a "panel" presentation, so you would not be able to be present during the review. However, the reviewer is required to consider any material that was submitted by you or your doctor during the appeal process. Additionally, our letter informing you that your request was eligible for external review will outline the procedure for submitting any additional information that you feel is important to be considered by the reviewer.

If your request is determined to be eligible, Smart NC screens the IRO being assigned to your case to assure no conflict of interest exists with your insurance company, your doctor, or any other person or company involved with the insurance company's decision. To that end, we can assure a completely independent review.

How Long Will it be Before I Receive a Decision?
Decisions on cases accepted for standard review are required to be made within 45 days of your request. For situations where a request for expedited processing has been granted, a decision is required within three days. You will receive the decision directly from the IRO.

What if I Have More Questions?
The regular business hours for Smart NC are 8 a.m. to 5 p.m., Monday through Friday. We can be reached at:

Phone:
855-408-1212 (toll free)
919-807-6865 (FAX)

Mailing Address:
NC Department of Insurance
1201 Mail Service Center
Raleigh, NC 27699-1201

Physical Address:
NC Department of Insurance
Boylan Building
11 South Boylan Avenue
Raleigh, NC 27603