How do I learn more about my right to external review?

Look at the information on your Explanation of Benefits (EOB) or on the final denial of the internal appeal by your health plan. Your policy, certificate, membership booklet, summary of benefits, or outline of coverage should include a description of the company's appeal procedures.

What if the claim is still denied after external review?

The Health Carrier External Review Act at Neb. Rev. Stat. § 44-1311 states that external review decisions are binding on the claimant, as well as the insurer, except to the extent they have other remedies available under the law. You cannot refile with the Department of Insurance for another external review of the same claim denial.

If the matter is not resolved in your favor, you may still file a written complaint with this office but the Department cannot overturn the external review decision. Claimants are strongly encouraged to exhaust their internal and external appeal rights before filing a complaint with the Department. As an administrative agency, the Department of Insurance is limited in what it can do to assist. It does not have medical personnel on staff, nor does it have statutory authority to require a carrier to pay for the services in question. In contrast, independent review organizations that perform external reviews are impartial medical professionals with authority to uphold or overturn claim denials.

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Appealing A Health Plan Decision

Nebraska Department of Insurance
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How do I appeal a health plan decision?

If your health insurer refuses to pay a claim or rescinds your coverage, you have the right to ask the company to reconsider its decision. Insurers have to tell you why they've denied your claim or ended coverage, and they have to let you know how you can dispute their decisions.

There are two stages to the process for appealing a health plan decision:

1. **Internal appeal**: If your claim is denied or your health insurance coverage is cancelled, you have the right to an internal appeal.

2. **External review**: For certain types of claims denials, after you have completed the internal appeal process, you have the right to request an external review by an independent third party.

If waiting the usual number of days for an internal or external appeal decision would seriously jeopardize your life or health, or if delayed treatment would jeopardize your ability to regain maximum function, you may request the expedited version of both internal appeals and external reviews.

Please note the appeal procedures described herein do not apply to specified disease, specified accident, accident only, credit, dental, disability, hospital indemnity, long-term care, vision care, Medicare supplement, workers' compensation or automobile medical payment plans.

"Grandfathered" health plans—plans that were in existence on March 23, 2010 and have not substantially changed—are not subject to external review requirements.

Internal Appeal

If you file a claim and your health plan denies the claim, then the Health Carrier Grievance Procedure Act, Neb. Rev. Stat. §§ 44-7301 to 44-7315, gives you the right to file an internal appeal.

To file an internal appeal, you need to:

- ☑ Complete all forms required by your health insurer, or you can write to your insurer with your name, claim number, and health insurance ID number.
- ☑ Submit any additional information you want the insurer to consider, to help explain why you believe the company's decision was wrong. Often a letter from the doctor justifying the medical necessity can be helpful.

You must file your internal appeal within 180 days (6 months) of receiving notice that your claim was denied. If you have an urgent health situation, you can ask for an external review at the same time as your internal appeal.

What kinds of denials can be appealed?

You can file an internal appeal if your health plan won't authorize services or refuses to pay the portion of health care expenses you believe should be covered. Denial reasons that plans might use are:

- The benefit isn't offered under your health plan;
- You received health services from a health provider or facility that isn't in your plan's approved network;
- The requested service or treatment is "not medically necessary";
- The requested service or treatment is an "experimental" or "investigative" treatment;

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- You're no longer enrolled or eligible to be enrolled in the health plan; or
- It is revoking or canceling your coverage going back to the date you enrolled because the insurance company claims that you gave false or incomplete information when you applied for coverage.

What papers do I need?

Keep copies of all information related to your claim and the denial; both the information you submit and the responses you receive. If necessary, you can request copies of your entire claim file free of charge from the insurance company. Examples of important records are:

- The Explanation of Benefits forms or letters showing what payment or services were denied, and why.
- A dated copy of the request for an internal appeal that you sent to your insurance company.
- Any additional information you sent to the insurance company; for example, a letter or medical records from your doctor.
- A copy of any letter or form you signed authorizing your doctor or anyone else to file an appeal for you.
- Notes and dates from any phone conversations you have with your insurance company or your doctor that relate to your appeal. Include the day, time, name, and title of the person you talked to and details about the conversation.

How long does an internal appeal take?

Your internal appeal must be completed within 15 working days after the insurance company received your request for review. For some claims, if the insurer cannot complete the review within 15 working days, it may take up to an additional 15 working days.

What if my need for care is urgent and I need a faster decision?

Expedited appeals are completed within 72 hours and are available:

- In urgent situations when waiting 15 working days would jeopardize your life or health, or if waiting 15 working days would jeopardize your ability to regain maximum function, you can request an expedited appeal; or
- When a covered person has received emergency services but has not been discharged from a facility, for all claim denials concerning an admission, availability of care, continued stay, or health care service.

Expedited internal appeal and external review can be done concurrently in the rare cases where waiting 72 hours for internal appeal would jeopardize the patient's life or ability to regain maximum function.

What if my internal appeal is denied?

At the end of the internal appeal process, your insurance company must provide you with a written decision. For certain types of claim denials, if your insurance company still denies a service or payment for a claim, you can ask for an external review. The insurance company's final determination must tell you how to ask for an external review.

External Review

The Health Carrier External Review Act, Neb. Rev. Stat. §§ 44-1301 to 44-1318, gives you the opportunity for a neutral third party to review a denied claim**.**

What types of denials can go to external review?

- A determination that a covered health care service does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness; or
- A denial for the reason that a treatment is experimental or investigational.

What if the denied medical service or drug is not covered?

- If the insurer denies your claim based on a policy exclusion, the insurer must tell you which provision is the basis for the denial.
- If the exclusion is for investigational or experimental treatment, you still qualify for external review.
- If you have an individual or small group policy, federal law gives you the right to ask your insurer to cover a drug that does not appear on the insurer's formulary. Check your policy's appeals section for details.

What are the steps in the external review process?

1. Initial Paperwork: You have four months from the date you receive a denial notice to request external review. Your insurer will provide you with an external review request form, or you can obtain the form on the Department website. Instructions for submitting the external review request are included on the form. Please be sure to complete all required fields and sign the form. Your signature is required.

- If you want to appoint an authorized representative, including your health care provider, the external review paperwork includes a form for you to use.
- If you request expedited external review or you challenge a denial of an experimental or investigational medical treatment, there are additional pages in the external request that your physician must complete.

2. Eligibility Determination: A preliminary review will determine whether the request is complete and whether the request is eligible for external review.

3. Independent Review: Complete and eligible requests will be assigned to an independent review organization ("IRO"). The IRO will also consider your medical records, doctor's recommendation, insurance policy, and other medical or clinical data.

4. Decision: The IRO will provide a written notice to uphold or reverse the insurer's claim denial within 45 days after receipt of your external review request.

What if I need a faster decision?

Expedited external review takes no longer than 72 hours and is available if:

- Your doctor can certify that you need expedited review in urgent situations, when waiting 45 days would jeopardize your life or health, or if waiting 45 days would jeopardize your ability to regain maximum function; or
- You are appealing a decision about admission, availability of care, continued stay, or health care service for which you received emergency services, but have not been discharged from a facility.