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. Additional information can be found on the federal government's website at **www.healthcare.gov/how-do-i-appeal-a-health-insurance-companys-decision/.**

Can I appeal to the Nebraska Department of Insurance?

If an insurer denies a claim or a portion of a claim and the claimant objects, the insurer must notify the claimant in writing that he or she may have the matter reviewed by the Nebraska Department of Insurance; however, 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, individuals conducting external reviews are impartial medical professionals with authority to uphold or overturn claim denials.

External review decisions are binding on the claimant, as well as the insurer. 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.

Nebraska Department of Insurance
PHONE (402) 471-2201
FAX (402) 471-4610

CONSUMER HOTLINE: 1-877-564-7323
TDD (800) 833-7352
VOICE (800) 833-0920
www.doi.ne.gov

If special accommodations or alternate formats of material are needed, please let us know.

Appealing A Health Plan Decision

Nebraska Department of Insurance
941 O Street, Suite 400
Lincoln, NE 68508

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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 cancelled, you have the right to an internal appeal. You may ask your insurance company to conduct a full and fair review of its decision. If you have a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed, your insurance company must speed up this process if you request an expedited appeal.

2. **External review**: Once you have completed the internal appeal process you have the right to request an external review by an independent third party. If you have a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed, you may request an expedited external review when you request an expedited internal appeal. External review means the insurance company no longer gets the final say over whether to pay a claim.

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.

Internal Appeal

If you file a claim and your health plan denies the claim, you then have 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, and that explains 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;
- Your medical problem began before you joined the 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;

- 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're required to sign if you choose to have your doctor or anyone else 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 30 days if your appeal is for a service you haven't received yet. Your internal appeal must be completed within 60 days if your appeal is for a service you've already received.

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

In urgent situations, you can request an external review even if you haven't completed all of the health plan's internal appeals processes.

You can file an expedited appeal if the timeline for the standard appeal process would seriously jeopardize your life or your ability to regain maximum function. You may file an internal appeal and an external review request at the same time.

A final decision about your appeal must come as quickly as your medical condition requires, and at least within 4 business days after your request is received. This final decision can be delivered verbally, but must be followed by a written notice within 48 hours.

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. 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

Until Nebraska's external review process takes effect in 2014, the federal government's Department of Health and Human Services (HHS) will oversee an external review process for health insurance companies. Insurance companies may choose to participate in an HHS-administered process or contract with independent review organizations. Please note that "grandfathered" health plans—plans that were in existence on March 23, 2010 and have stayed basically the same—are not subject to federal external review requirements.

What types of denials can go to external review?

- Any denial that involves medical judgment where you or your provider may disagree with the health insurance plan;
- Any denial that involves a determination that a treatment is experimental or investigational; or
- Cancellation of coverage based on your insurer's claim that you gave false or incomplete information when you applied for coverage.

What are the steps in the external review process?

You must file a written request for an external review within four months of the date your insurer sent you a final decision. If your insurer has elected to participate in the HHS administered process, you can call toll-free 1-877-549-8152 to request an external review request form.

You can fax your external review request to 202-606-0036; mail the request form to P.O. Box 791, Washington, D.C. 20044; or submit your request via email to **disputedclaim@opm.gov**.

If your insurer has contracted with an independent review organization (IRO), you'll find contact information for the IRO on your Explanation of Benefits form or on the final denial of the internal appeal by your health plan.

The external reviewer will issue a final decision, either upholding your insurer's decision or deciding in your favor. You and your insurer are required by law to accept the external reviewer's decision.

Can someone file an external review for me?

You may appoint a representative, such as your doctor or another medical professional, who knows about your medical condition to file an external review on your behalf. An authorized representative form is available at **www.externalappeal.com**.

How long does external review take?

Standard external reviews are decided as soon as possible—-no later than 60 days after the request was received. If your situation is urgent, the external review will be conducted as expeditiously as possible. An urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision.