THE HENRY J. KAISER FAMILY FOUNDATION

Consumers Union

A CONSUMER GUIDE TO HANDLING DISPUTES WITH YOUR EMPLOYER OR PRIVATE HEALTH PLAN, 2005 UPDATE

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INTRODUCTION

Most people now get their health care through some form of managed care plan – a health maintenance organization (HMO),[1] preferred provider organization (PPO),[2] or point-of-service plan (POS).[3] These plans "manage" care by monitoring the medical care used by their enrollees to make sure it's medically necessary and cost-efficient, and by providing restrictions or incentives to use certain health care providers. Even traditional indemnity plans[4] have incorporated elements of utilization review to keep costs under control.

Most of the time, people covered by health plans (the common term now for all types of health insurance and health plans) receive the care they need. But when a health plan decides that the care you or your doctor want is not medically necessary, limits your care in some way, or denies payment for your care, the potential for a dispute arises. The health plan may be justified in refusing to provide or pay for treatment if it is not considered medically necessary, not necessary in your situation, or not covered by your policy. The cases most likely to end up in dispute are often not clear-cut, such as treatments that may be new and experimental, whose value may be unproven.

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[1] An HMO typically requires all your care to be arranged and approved through your primary-care physician. Except for emergency care, you must receive care from providers (hospitals, doctors, and therapists) who are part of the HMO network.

[2] A PPO plan allows you to use any providers (hospitals, doctors, and therapists) that you choose, but you will pay less if you use health care providers that are part of the PPO network.

[3] A POS plan is an HMO that allows you to obtain services from providers such as hospitals, doctors, and therapists who are not part of the HMO network, but you will pay less if you use providers within the network.

[4] Indemnity plans (also known as fee-for-service plans) were the predominant type of health insurance available before managed care plans such as HMOs and PPOs became available; typically you can use the provider of your choice, and the plan will pay a certain percentage of the reasonable and customary fee charged by the provider.

You have certain rights under federal and state laws if you disagree with a decision your health plan makes about your medical coverage. The rights that you have depend on the type of health plan you have and the state in which you live. Note that in some states, the state laws apply to all of the various types of insurance coverage (HMOs, PPOs, POS plans, and indemnity insurance, whether available from insurance companies, Blue Cross/Blue Shield plans, or employers), while in other states the laws may be limited to specific types of managed care plans such as HMOs.

Both federal and state laws apply to a health plan's "*internal review*" process, the review of denials that are conducted by the health plan. If you have an employer-sponsored health plan (a plan that you enroll in through your work), the federal government has requirements that employer-sponsored health plans must follow for processing claims and for internal review of appeals. If you have a health plan that you purchased on your own, your state has laws and rules that your health plan must follow for internal review of claims denials. In general, a state's rules apply to internal review by insured health plans (whether employer-sponsored or not), as long as the state's rules don't conflict with the federal rules.

In recent years, most states have expanded your ability to appeal a health plan's denial of benefits by setting up their own process for "*external review*," or the reconsideration by an outside, independent organization of a health plan denial. These "external reviews," or "independent reviews" as they are often called, provide an unbiased way to resolve disputes between patients and their health plans. The review is typically made by a person or panel of individuals who are not connected to the health plan. As of December 2004, 43 states plus the District of Columbia had external review programs.[5]

[5] This Guide's total for the number of states with external review programs may differ from the total in other studies because of the different ways of defining what constitutes an external review program. This Guide includes state external review programs that review health plan denials based on whether the health services were medically necessary or experimental, and also contractual disputes. See Section 5 of this Guide under "What you can appeal" to determine what types of denials your state's program covers.

This Guide will help you navigate your plan's internal appeals procedure and your state's external review process for disputes with your employer or private health plan. You cannot use this Guide, however, for resolving disputes with your Medicare or Medicaid health plan because these programs have their own procedures for resolving disputes.

Section 1 of this Guide, "Know Your Coverage," is important to read before you have a dispute. Many disputes arise because people don't know what type of health plan they have or what services are not covered by their plan. You can avoid a lot of hassle by knowing this information. There may be referral or payment rules that you need to follow. At the end of Section 1, we present some questions to help you diagnose your coverage and dig into the important details.

Section 2, "Appealing To Your Health Plan," discusses how to use your health plan's internal appeals process. All states require health plans to have internal review procedures, and the federal government requires employer-sponsored plans to follow certain rules for internal review. The internal appeal is an important step for consumers to understand because many disputes are resolved during this process, and because most state laws require you to complete the internal appeal process before using the state's external review process.

Section 3, "Getting an Independent Opinion – External Review in Your State," explains what to expect if you use your state's external review process.

Section 4, "How Consumers Fared Under External Review Programs," describes some of the experiences states have had with their external review programs.

Section 5, “State-by-State External Review Programs,” provides a summary of the important aspects of each state’s external review procedures and whom to contact for further information. If you think you want to appeal a health plan decision, reading about your state’s program will get you started.

SECTION 1 -- KNOW YOUR COVERAGE

The best way to avoid the aggravation and anxiety that often accompanies a dispute with your health plan is to know your coverage and follow the health plan's procedures for referrals and approvals. Many disagreements between patients and their health plans occur because patients do not have a clear understanding about how their health plan works or which services it will cover. You need to understand this information *before* a problem arises so you will be able to make effective decisions about your care and who will provide it.

Evidence from states that track external review results indicates that many people do not understand the coverage that is provided by their health plans. If you have not yet read all of your policy or the Summary Plan Description, read it now. If a dispute does arise with your health plan, you need to understand what type of health plan you have in order to know what rights you have – in other words, what internal review requirements you and your plan must follow and whether you can use your state's external review program. These requirements may vary depending on whether you have coverage through your employer, or whether you purchased coverage on your own directly from a health plan (though you may have used an agent or an on-line broker to purchase the health plan) or an association-sponsored health plan.[6]

Understand What Type of Coverage You Have and What Laws Apply

Most people with private insurance are covered by an *employer-sponsored health plan*. An employer-sponsored health plan is one that you and your family enroll in through work and to which the employer generally makes a contribution toward the cost of coverage. *Individually purchased coverage* is insurance you purchase directly from a health plan or from an association-sponsored health plan, and you pay the entire premium

[6] An association-sponsored health plan is one sponsored by a trade or professional organization or a business coalition.

yourself. Different laws may apply depending on whether you have employer-sponsored coverage or individually purchased coverage, so it is important that you know which type you have.

What You Need to Know About Your Employer-Sponsored Coverage

If you are enrolled in an employer-sponsored health plan, your right to appeal disagreements about benefits through your plan's internal appeals process is determined by federal law (the Employee Retirement Income Security Act, or ERISA) and a federal ERISA regulation that became effective January 1, 2003. You may have other rights under your state's laws if they don't conflict with the federal requirements. Whether you have rights under state law for external review will depend on whether your health plan is *insured* or *self-funded*. An employer health plan is insured if the employer purchases health coverage from an insuring organization such as a commercial insurer, a Blue Cross or Blue Shield plan, or an HMO. An employer health plan is self-funded if the employer pays for the health care costs of its employees directly rather than purchasing insurance from an insuring organization.

It is sometimes difficult for consumers to know whether their employer-sponsored plan is insured or self-funded. You may think your coverage is from a health insurance company like CIGNA or Aetna, but if you work for a large employer, those insurance companies may not actually be insuring you. Instead, they may simply process the claims as a "third-party administrator" for your employer's self-funded plan. To find out whether your employer-sponsored plan is self-funded, ask the person who administers the benefits where you work. You also can look in the Summary Plan Description that you received from your employer when you enrolled, but sometimes the language is ambiguous on this issue, so it is best to ask. If you can't find out from your employer or the Summary Plan Description, you can contact the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, which is the agency that enforces ERISA's provisions. Either call EBSA at 1-866-444-3272, or find an EBSA regional office at http://www.dol.gov/ebsa/aboutebsa/org_chart.html#section13.

If you are enrolled in an employer-sponsored plan that is *insured* (your employer purchases insurance from an insuring organization), you have rights under federal and state laws if you have a coverage dispute. An insured employer health plan must follow federal ERISA regulations for internal plan claims procedures and review of disputed claims (described later in this Guide) and may also be required to follow state rules if they do not conflict with the federal regulations. Although ERISA prevents some state laws from applying to employer-sponsored health plans that are insured, in a 2002 case the U.S. Supreme Court found that a state could apply its external review law to a claim dispute involving an insured employer-sponsored health plan. Although this area of law remains somewhat unsettled, consumers should assume that their state's laws apply unless a court says that they do not. Section 5 of this Guide will tell you if your state has enacted an external review law and how the program works in your state.

If you are enrolled in an employer-sponsored health plan that is *self-funded* (the employer pays employee health care costs directly), your source of help will be the health plan's internal appeals process as required by the federal ERISA regulations (described later in this Guide). State internal review rules will not apply, and *you will not be able to use your state's external review process*. If you are in a self-funded health plan and are not satisfied with the results of your plan's internal review process, you may have legal rights that you can pursue in a court of law. If the dispute is a large one or involves what you consider to be necessary medical care, you may want to consult a lawyer about your legal rights.

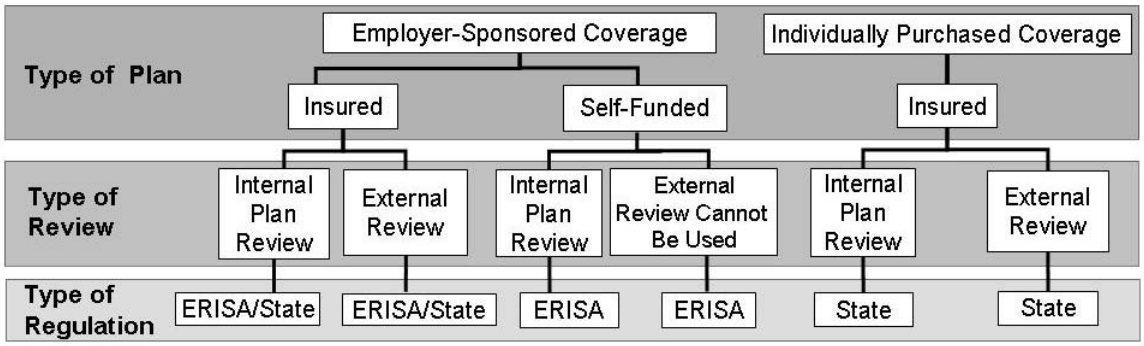
What You Need to Know About Your Individually Purchased Coverage

If you purchased insurance directly from a health plan or from an association-sponsored health plan (you may have used an agent or an on-line broker to purchase the health plan), your health plan's procedures and the laws of your state will determine if you can appeal a dispute over benefits using the plan's internal procedures, and state law will determine whether you can appeal a plan's decision to a state external review

organization. Most states have laws that provide for internal and external review of disputes over coverage you purchase as an individual. See Section 5 of this Guide for the rules in your state.

Here's an easy way to see which regulations apply to these two types of health plans:

TYPE OF REGULATION DEPENDING ON TYPE OF HEALTH PLAN



Understand What Services Are Covered

Understanding the services that your health plan covers is also important. You can begin by looking at your health plan contract. It will contain information about the benefits your plan will pay for, what it will not pay for, and the amounts you will be required to pay when you use health services.

If you are enrolled in an employer-sponsored health plan, you probably received what is called a Summary Plan Description when you first signed up. Although this document may summarize your coverage in language that's easy to understand, it is not the legal document that will be used if your dispute with your health plan ends up in court. For a complete description of your plan's benefits, contact your employer's human relations department to see a current copy of what is known as the "Evidence of Coverage" or "Certificate of Insurance." If you bought your own health plan, you should have received the Evidence of Coverage when you bought the policy. If you are not sure if you have a current copy, check with your health plan's customer service department or your insurance agent.

Health plans limit or exclude payment for many types of services, so make sure you learn about the services your plan does not cover. Excluded services might include infertility treatments, acupuncture, cosmetic treatments, and treatment of obesity. Individually purchased plans may exclude coverage for pregnancy benefits, substance abuse, mental health care, or nursing home care.

Understand Your Plan's Rules

Knowing your plan's rules about such things as referral procedures and payments for out-of-network services will help prevent problems that may later lead to claims disputes.

Referral and Approval Rules

Some health plans require patients to get a referral from their primary care doctor before going to a specialist or before receiving certain services. The primary care doctor acts as a "gatekeeper" to oversee and coordinate your care. Your primary care physician's office may have requirements regarding when and how you get referrals to specialists or other services. If your doctor provides the referral, be sure to ask when the referral must be renewed and how you get it. For example, the plan may initially authorize a limited number of visits to a specialist for your condition. If you need more, will you be able to obtain approval over the phone, or will you need to schedule another visit with your primary care physician?

You may need pre-authorization by the health plan for some services such as surgeries. Often the doctor's office will contact your health plan to obtain this pre-authorization. For some plans you may need to contact the health plan directly. A phone call to the health plan before your surgery to verify that all authorizations are in order is far easier than finding out that approval has not been granted or paperwork is missing when you show up at the hospital.

Although these details may seem trivial to you now, many disputes arise when payments are denied because the patients did not obtain proper referrals and pre-authorizations.

Using Non-Network Services

Most health plans negotiate payments with doctors and hospitals in order to lower the cost of care. As a result, your health plan contract may stipulate that you must use "in-network" doctors and hospitals in order to obtain coverage. However, even if your plan is an HMO that requires you to use in-network providers, you may be allowed to use out-of network providers in certain cases. For example, Minnesota requires that HMOs

"must pay for highly specialized medical care that is not available in network."[7] You also may need to use out-of-network services in emergencies or when you are traveling. If you can, you should contact your health plan before using out-of-network services or, in emergency cases, as soon as reasonably possible after you have begun to receive care. Your health plan has rules governing when and how you may obtain coverage for services obtained from out-of-network providers. These rules should be described in your Summary Plan Description.

Many people choose health plans such as a PPO (preferred provider organization) or a POS (point-of-service) plan that also cover services provided doctors or hospitals that are not part of the plan's network. If you have a health plan such as a PPO or POS plan that allows you to go to doctors or hospitals that are not part of its network, be aware that the amount the plan will pay for the services you receive may be less than what the doctor or hospital bills. If the out-of-network provider charges more than what the health plan claims is reasonable, you will have to pay the difference, plus any coinsurance.

For example, PPO or POS plans usually require you to pay coinsurance (often 20 or 30 percent or more) of their "allowable charge" for services from providers who are not part of the network. Suppose your out-of-network coinsurance percentage is 20 percent. If the doctor charges $100 for a service and your health plan's allowable charge for that service is only $80, you will pay the $20 difference plus 20 percent of the $80 allowable charge, for a total of $36. Obviously, for complicated procedures and treatments, these out-of-network charges add up. You may unwittingly incur these extra out-of-network charges when you have surgery. It is common for the surgeon and the hospital to be in-network providers, but the anesthesiologist who puts you to sleep may not be in the health plan's network. Even though patients rarely have the opportunity to select the anesthesiologist, some health plans maintain that you are responsible for these

[7] http://www.health.state.mn.us/divs/hpsc/mcs/referral.htm.

out-of-network charges. At least one state external review case has upheld such a determination – in March 2003, the Michigan Commissioner of Insurance ruled in favor of the plan when the consumer used an out-of-network anesthesiologist.[8] Your health plan has rules about coverage of services obtained from out-of-network providers. These rules should be described in your Summary Plan Description. See if you can find out from your doctor which anesthesiologist or anesthesiology group will be used, so you ask your plan whether they are in the plan's network.

Checklist For Diagnosing Your Coverage

Knowing your coverage will help avoid misunderstandings. Review your plan documents and complete the following worksheet to (1) make sure you understand your coverage, and (2) have the necessary information ready in a convenient place when you need to arrange care. What follows is a checklist to help you remember information about your coverage:

[8] PRIRA Cases (Patients Right to Independent Review Act), File No. 51806, March 11, 2003 -- http://www.michigan.gov/cis/0,1607,7-154-10555_20594_20596-76700--,00.html, accessed May 13, 2005.

MY HEALTH PLAN COVERAGE

My health plan coverage is through:

- [ ] My employer -- check if:
  - [ ] my plan is an insured plan; any plan denials are eligible for state external review
  - [ ] my plan is a self-funded plan; any plan denials are NOT eligible for state external review
- [ ] A policy I bought myself
- [ ] An association-sponsored policy (such as through a trade or educational organization)
- [ ] Other: _____

My health plan is a:

- [ ] Health maintenance organization (HMO)
- [ ] Preferred provider organization (PPO)
- [ ] Point-of-service plan (POS)
- [ ] Traditional indemnity (also known as fee-for-service)

Plan number to call if I have a problem: _____

My primary-care physician is: _____

Physician's phone number: _____

I need a referral from my primary-care physician for:

- [ ] Lab and x-ray tests
- [ ] Gynecologist (for well-woman exam)
- [ ] Gynecologist (for other concerns)
- [ ] Pediatrician
- [ ] Other specialist visits
- [ ] Surgery
- [ ] Other: _____

My primary care physician has the following requirements for obtaining referrals:

- [ ] Requires an office visit
- [ ] Requires _____ days advance notice
- [ ] Other: _____

My primary care physician can refer me to specialists who:

[ ] Are part of his or her group practice
[ ] Are on the health plan network list
[ ] Are outside of the health plan network *only if there are no similar specialists within the network*
[ ] Are outside of the health plan network

--OR--

[ ] I do not need a referral from my primary-care physician

I have reviewed the Exclusions and Limitations section in my Evidence of Coverage. My health plan will not pay for or limits the following services:

[ ] _____
[ ] _____
[ ] _____
[ ] _____
[ ] _____

My plan will cover services at the following hospitals:

_____
_____
_____

What should I do if I need care while I am out of my plan's service area?

For non-urgent care: _____
phone: _____

In an urgent situation: _____
phone: _____
In an emergency: _____
phone: _____

If you have a PPO or POS plan:

Although I can use out-of-network doctors for most services, I <u>cannot</u> use out-of-network doctors for the following services:

[ ] Mental health
[ ] Substance abuse
[ ] Other: _____

If I use out-of-network providers, I will pay:

[ ] $_____ annual deductible
[ ] _____% coinsurance for charges exceeding the deductible

SECTION 2 -- APPEALING TO YOUR HEALTH PLAN

Disputes with health plans arise over whether services are covered, which treatments should be provided, which providers should be used, how much a service should cost, difficulties dealing with providers, and even billing and administrative mistakes. In most cases, your health plan will have an established appeals process to handle these disagreements. For employer-sponsored health plans (both insured and self-funded), federal ERISA regulations establish procedures and timelines for disputes involving claims for benefits (i.e., whether a service is covered and how much it should cost). Also, states have their own rules about how health plans must conduct their internal appeals. Even if you are eligible to use your state's external review procedure, you will usually have to complete your health plan's internal appeal process first, so it is important to learn how that process works.

Health plans can have different appeals processes for different types of disputes. For example, a health plan may have a different process for resolving a complaint about appointment times than for an appeal involving a denial of a benefit or a refusal to authorize a medical procedure. Federal ERISA regulations set up other requirements for employer-sponsored health plan appeals, such as requiring health plans to let you see the documents used to determine whether or not you have coverage for the services in dispute, allowing no more than two levels of review, and prohibiting a fee for the review.

Preparing an Informal Appeal

You may find yourself entering the dispute process when you or your physician attempt to get pre-authorization approval before you receive a health care service, and the approval is denied. Or you may find yourself entering the process when you receive an Explanation of Benefits (EOB) form from your health plan saying that your claim for a service is denied.

The first thing you should do is look in your Summary Plan Description or your Evidence of Coverage booklet to see whether the denied service is covered by your plan. If you don't understand your coverage, or if you don't agree with the denial, you should contact your plan's customer relations department. Although many disagreements will be resolved at this level, this may be just the first step in a lengthy process. Start your record-keeping immediately. Assemble a file containing any paperwork you already have, such as bills, EOBs, physician information, or physician referrals, and keep a log of every telephone call you make to the plan. Be sure to record the date and the name of the person you talk to and take notes about your conversation. Ask what will happen next and when it will happen. For example, if the health plan representative says he or she will have to find out some information and get back to you, ask when you can reasonably expect a reply. Mark that date in your notes and on your calendar. If you don't hear from the plan by that date, it's time for another phone call.

If your dispute involves a claim for an urgent medical problem, be sure to tell your health plan when you first communicate with its representative. There often are special rules and timelines for responding to urgent claims. Ask your plan what special rules apply for making an appeal for urgent health care needs.

Preparing a Formal Appeal

If your attempts to deal with the health plan informally are not successful, you will have to file a formal appeal. Health plan procedures vary, but all will require details about your appeal to be submitted in writing. Some plans allow you to initiate the appeal on the telephone, but then will ask you to complete a form and submit it before the process can continue. If your plan does not provide an appeal form, consult your Summary Plan Description or the Evidence of Coverage for a description of the appeal process. Look for specific information the plan needs to process your appeal. Be sure to provide answers to all questions. You don't want to add to the delay by forgetting to supply crucial information. Be sure to keep a copy of your written appeal.

Expect to provide the following information in your written appeal:

- Your name, address, telephone number,
- Your insurance plan number or group code and member identification number or Social Security number,
- Your provider's name and bill,
- Referrals to specialist services,
- Description of the service or procedure that you want to have covered,
- Information supporting why the service should be covered (including your symptoms and treatment history),
- Recommendations and referrals from your doctor explaining why the treatment or procedure should be covered,
- Explanation of Benefits (EOB) forms,
- References to the sections of the Evidence of Coverage that apply to your situation,
- Additional research on your medical condition or treatment, such as treatment guidelines, information from medical journal articles, or research that says the treatment is more cost-effective in the long term,
- Documentation that the services are covered by the Medicare program or are required by state law.

You may have to file your appeal within a specified time period; it is vital that you do so. For example, the health plan may say it must receive your appeal within one year of the date of treatment, or within 60 days of the date the plan tells you it's not paying your claim, whichever comes first. Federal ERISA regulations require that employer-sponsored health plans (both insured and self-funded) must give you at least 180 days to file an appeal. Know your plan's timetable for all stages of an appeal. Again, if your dispute involves an urgent need for health care, make sure that you understand and follow any special procedures and timelines that apply in such cases.

Health Plan Review

Once the plan receives your written appeal, it will investigate the appeal and make a determination setting out what the plan is willing to do. This procedure goes by different names at different health plans; it may be called an internal review, a level I appeal, or a desk review. The key feature is that this is the first step in the formal plan appeal process.

At this level of review, you may or may not have further contact with the health plan. Some plans allow for informal discussions or consultations between the person making the appeal and the person who is

reviewing it. Other health plans will review the documentation for your case and notify you only after making a decision. Note that federal ERISA regulations applicable to employer-sponsored health plans (both insured and self-funded) provide consumers with the right to present written comments, documents, records, and other evidence to the health plan for consideration in the appeal process.

Response times vary from plan to plan depending on the type of dispute. The plan will usually act more quickly if the service has not yet been provided, or if the patient is already in the hospital. Some health plans say that they handle the first level of reviews within one business day for services not yet provided, but other plans may take longer. The federal ERISA regulations applicable to employer-sponsored health plans set maximum response times for different types of appeals: 30 days if the service has not yet been provided, or 60 days if it has been provided. State law also may establish response times for appeals to individually purchased health plans.

Health plans may have expedited processes to deal with requests for medical services that your doctor feels are urgent. If your appeal involves an urgent need for care, make that clear to the health plan so it can expedite your appeal. Federal ERISA regulations require employer-sponsored health plans to respond to an urgent care claim within 72 hours.

If you do not agree with the results of the plan's initial review, most plans allow you to appeal the decision to a panel of individuals who were not involved in the initial decision. In some cases you will be asked to appear at a hearing to discuss your case; in others you will not. Each health plan has its own rules about who will be members of the review panel. It may include physicians, consumers, or sometimes representatives of the health plan. Federal ERISA regulations applicable to employer-sponsored health plans require that if the appeal involves a medical judgment, the reviewers must consult with a qualified health care professional.

If your plan is subject to state external review requirements, it will usually notify you that it has denied your appeal and tell you how to file for an external appeal.

Here is a checklist to help you keep track of your appeal. Keep this information handy, and update it if you change your health plan.

WHO TO CONTACT REGARDING A HEALTH PLAN APPEAL

Who to call: _____

Where to write: _____
_____
_____

How soon must I appeal? _____

How many days will it take to receive a response? (List the response times for each level of review)

1st level _____
2nd level _____
Expedited appeals (for medical emergencies) _____

Note: Federal ERISA regulations for employer-sponsored health plans provide that a health plan can't require more than two levels of appeals, and that if two levels are used, both must be completed within the response time allowed by the regulations.

Arbitration

Your health plan may offer or in some cases may require that you resolve your dispute through a process called arbitration. Arbitration is a process in which two parties present their views of a dispute to a neutral third party -- an arbitrator -- who will then decide how to resolve the dispute. Arbitration may be binding, in which case the parties agree ahead of time to abide by the arbitrator's decision, or it may be non-binding, in which case the arbitrator's decision is simply advisory.

Federal ERISA regulations provide that if an employer-sponsored health plan uses arbitration as part of its internal review, the arbitration must follow the same federal

rules that apply to any internal appeal, including one that says you cannot be charged a fee for the arbitration.

If your employer-sponsored health plan requires that you enter into mandatory arbitration, it must be one of the two allowed levels of internal appeal, and you may challenge the arbitrator's decision in court (in other words, the arbitrator's decision can't be binding).

Your employer-sponsored plan may offer you voluntary arbitration (including binding arbitration), but only if you have completed the plan's internal review and the plan has provided you with sufficient information to enable you to make an informed judgment about whether or not to use voluntary arbitration. If your health plan has voluntary arbitration, your decision to use or not use this alternative does not affect your rights to any other plan benefits such as payment for other covered treatments. If you decide not to use voluntary arbitration, your health plan cannot use this against you in subsequent appeals.

Also, your state may have rules that regulate how your plan can use arbitration. If your plan requires that you agree to arbitration to settle disputes over claims for benefits, you may want to contact your state insurance commissioner to determine what your rights might be.

SECTION 3 -- GETTING AN INDEPENDENT OPINION -- EXTERNAL REVIEW IN YOUR STATE

If you are not satisfied with your health plan's decision after completing the plan's internal appeal process, you may be able to appeal the plan's denial to your state's external review program. Most states have external review programs, but the details of these programs vary considerably. External review programs differ from state-to-state in the types of disputes that are eligible for appeal, the process used to resolve the appeal, and the time limits imposed at each step of the process. This section describes the variations found in states' external review programs. Consult the state-by-state tables in Section 5 of this Guide to learn specific requirements for your state and who to contact for further information.

Who Can Appeal

In most states, state external review requirements apply to all types of health plans. In a few states, they apply only to managed care plans (such as HMOs, PPOs, or POS plans), or just to HMOs.

You can use your state's external review program if your health plan is an insured employer-sponsored plan or a private plan that you have purchased on your own. Remember, state external review laws do not apply to employer-sponsored health plans that are self-funded, so if you are in a self-funded plan, you cannot use your state's external review procedure. At this time, your only recourse is to sue in court. State external review programs also do not apply to Medicare and Medicaid beneficiaries. If you are a Medicare beneficiary, you must follow the Medicare review process described in your Medicare Handbook. If you are a Medicaid beneficiary, you can ask your state or local Medicaid office about their appeal procedures.

In most states, you can give someone else written authorization to appeal for you. In many states, your provider may appeal on your behalf with your written authorization.

What Types of Problems You Can Appeal

Most state insurance departments will review your request to be sure that it is eligible for external review before sending it on to an external reviewer. Most states require that the issue at stake involve "medical necessity." That means that you and your doctor must believe a particular procedure, treatment, or prescription drug is essential for your health and recovery. Your health plan, for a variety of reasons, may disagree. For example, your plan may believe a particular treatment is ineffective for your condition, so it will not pay for it.

You and your doctor may want a medical treatment, but your health plan will not cover the cost because it considers the treatment experimental or investigational. Most states will allow you to submit this type of dispute to external review.

Many states explicitly exclude disputes over coverage issues, such as whether you can use a non-network provider because no qualified network provider is available or whether you were actually enrolled in the health plan, though some states have a separate process for reviewing these non-medical necessity denials. Section 5 of this Guide tells you more about what types of problems your state will allow you to appeal through external review.

Several states require that your dispute involve a minimum amount of money, usually from $100 to $500. In other states, your right to appeal a claim is not limited by the amount of money involved.

When You Can Appeal

If you have a dispute over whether your health plan will pay for a particular treatment, you may have to proceed with treatment before knowing if the plan will pay for it. In many states, you will be able to submit your dispute for external review even if the services have been provided; in others you may submit your case only if services have not been provided. Section 5 of this Guide will give you the details for your state.

Most states require you to complete all the steps in your plan's internal appeals procedure before requesting external review. Some states specify time limits for the internal review, and some allow you to file for external review if you have not received a response from your plan within the required time. At least one state, New Mexico, allows you to file for external review at the same time you appeal to the health plan if your case is an emergency.

If you have completed all the steps in the internal appeals process, and you have not won your case, you should receive a notice of "adverse determination" or "adverse decision" from your health plan, along with instructions on how to file with the state for external review. Usually you must file within a specified period, say 30 to 90 days, after receiving the adverse determination in order to be eligible for external review.

If a delay in receiving services will cause you serious harm, most states have what is called an "expedited review" which will give you a decision in a much shorter period, usually 24 to 72 hours.

How to Appeal

Every state has a different procedure for handling external reviews. You will usually receive instructions for filing an external appeal when your internal appeal is denied by your health plan. In some states, you begin the external appeal by contacting your health plan again. Others require that you contact your state's department of insurance or other state agency to initiate your appeal.

The actual review may be performed by the state agency itself or through an independent review organization hired by the state or selected by the plan. Usually you do not have to pay for such reviews, though some states charge a nominal amount, usually $25 to $50. Several states have provisions to waive these charges if you demonstrate that they would cause financial hardship.

Although some states schedule a hearing and allow you to speak directly with the reviewer, most do not. In many states, it is not clear whether either you or your health plan must accept the decision made by external review. In such cases, you may be able to appeal to the court system if you are not satisfied with the result of your external review. You will likely need to contact a lawyer to determine what, if any, rights you may have if you are not satisfied with the results of an external review.

SECTION 4 -- HOW CONSUMERS FARED UNDER EXTERNAL REVIEW PROGRAMS

External review programs have been operational in most states for several years, so we now have information about how they are working. This section includes information about the mistakes people make that cause external appeals to be ineligible for review and whether the external reviews typically agree with or overturn health plan denials.

Mistakes That Make External Appeals Ineligible

Many appeals are not eligible for state external appeals programs for a variety of reasons. For example, in 2003 under Maryland's program, 69% of consumer appeals based on medical necessity could not be accepted because:

- the state did not have jurisdiction to decide the case -- for example, the health plan was a self-funded employer plan (41%, or 349 out of 1,229 non-accepted cases),
- the health plan's internal appeal process had not been completed (34%, or 289 cases), and
- the consumer failed to provide necessary information so the case was closed (14%, or 119 cases).[9]

Other states report similar experiences. North Carolina indicates that its external review program did not accept 53% of the requests it received for external review during the period January 1, 2003-December 31, 2004. The most frequent reasons for not accepting the requests were:

- the appeal did not involve a medical necessity determination (20%, or 38 of 188 non-accepted cases),
- the insurer's internal appeal process had not been exhausted (19%, or 35 cases),

[9] *The Maryland Insurance Administration's 2003 Report on The Health Care Appeals & Grievance Law*, August 2004, pp. 8-9 and unnumbered Appendix, at http://www.mdinsurance.state.md.us/documents/AppealsandGreivanceReport2003.pdf

- the external review program did not have jurisdiction -- for example, it was a self-funded employer plan (13%, or 24 cases), or
- the request was incomplete (11%, or 21 cases).[10]

These experiences demonstrate that many consumers make mistakes with their external review appeals, including filing with the wrong agency, failing to exhaust their health plan's internal appeal procedure, or failing to provide all the necessary information (such as consent forms) that is needed to investigate their case. It is important to understand and follow your health plan's internal appeal process and your state external review program's procedures and requirements as you pursue your appeal.

Many appeals are determined based on the exclusions contained in the health plan contract. Several states review applications for external review to determine whether the denied service is actually covered by the health plan's contract before sending it on to an external reviewer. Although most states do not publish statistics on the number of requests that actually concern contract disputes (rather than determinations of medical necessity or whether the treatment is experimental or investigational), the few statistics that are available suggest that misunderstanding of contract exclusions is widespread. It is important that you read a current version of your health plan contract to know what these exclusions are.

External Appeals Outcomes

The process of pursuing an appeal when you have a dispute with your health plan may not be easy, so you may want to know whether consumers are generally successful in their appeals. Whether external review programs decide in favor of the health plan or the consumer varies from state to state and typically depends on the type of health service in dispute. Keep in mind that in some states, the reviewers have authority to partially

[10] North Carolina Department of Insurance, *Healthcare Review Program Semiannual Report for the period January 1, 2003-December 31, 2004*, pp. 8-11, at http://www.ncdoi.com/consumer/erp/externalreviewreport5.pdf

overturn a health plan denial (e.g., allow the consumer to receive some of the service or some payment). Also, during the external review process, health plans sometimes reverse their denials without the reviewers requiring them to do so.

In Maryland's 2003 review of medical necessity appeals:

- consumers were successful about half the time (46%, or 175 of 378 cases), either because the health plan reversed itself during the investigation (29%, or 111 cases), or the health plan's decision was reversed by the reviewers (17%, or 64 cases);
- the health plan's decision was modified by the reviewers 3% of the time (11 cases); and
- the health plan's decision was upheld 51% of the time (192 cases).

In Maryland, consumers were less likely to win in certain types of cases. For example, reviewers ruled in favor of the health plan in 93% of appeals for cosmetic procedures, 93% of appeals for treatment of morbid obesity, and 69% of appeals regarding physician services (though the health plans later reversed themselves during 27% of physician services appeals).[11]

In North Carolina, consumers were granted relief through external review 45% of the time (43% of the health plan denials were overturned and in 2% of the cases, health plans reversed their denials decisions) during 2003 and 2004. In 2003, Maine consumers were successful 57% of the time (43% full reversals and 14% partial reversals of the health plan denials). The success rate for Texans who appealed in 2004 was 57% (49% in favor of the consumer and 8% partially in favor of both the consumer and the HMO). The success rate was 42% in Indiana in 2003, 39% in California in 2004, and 42% in

[11] *The Maryland Insurance Administration's 2003 Report on The Health Care Appeals & Grievance Law*, August 2004, pp. 8-9 and unnumbered Appendix, at http://www.mdinsurance.state.md.us/documents/AppealsandGreivanceReport2003.pdf

New York in 2003 (35% health plan denials were reversed in full and 7% were reversed in part).[12]

An earlier study with data from the late 1990s and early 2000s found that, on average, consumers were granted relief through external review almost half (45%) of the time. However, the percent varied by state, from a low of 21% in Arizona and Minnesota to a high of 72% in Connecticut. In addition, in about half of the states, reviewers could partially overturn a health plan denial, which they did, on average, 6% of the time.[13]

[12] "Success rate" is used to indicate the ratio of the number of appeals wholly or partially resolved in favor of the consumer (including reversals by the health plan, if noted) to the number of appeals closed during the period. Data sources: North Carolina: *Healthcare Review Program Semiannual Report for the period of January 1, 2003-December 31, 2004*, pp. 11-12, at http://www.ncdoi.com/Consumer/ERP/ExternalReviewReport5.pdf; Maine: *2003 Maine Consumer Guide to Health Insurers*, at http://www.state.me.us/pfr/ins/HealthGuide_External_Review.htm; Texas: *Complaint Data, Comparing Texas HMOs 2004*. p. 109, at http://www.opic.state.tx.us/docs/295_complaint2004.pdf; Indiana: *2003 Indiana External Reviews*, at http://www.in.gov/idoi/health/2003_external_review_report.html; California: *Annual Report 2004*, Department of Managed Health Care, Appendix A, pp. 29-30, at http://www.hmohelp.ca.gov/library/reports/complaint/2004.pdf; New York: *2004 New York Consumer Guide to Health Insurers*, pp. 29-31, at http://www.ins.state.ny.us/acrobat/hg2004.pdf.

[13] Kaiser Family Foundation, prepared by K. Pollitz et al., Georgetown University Institute for Health Care Research and Policy, *Assessing State External Review Programs and the Effects of Pending Federal Patients' Rights Legislation*, March 2002, pp. 3-4, at http://www.kff.org/insurance/externalreviewpart2rev.pdf.

SECTION 5 -- STATE-BY-STATE EXTERNAL REVIEW PROGRAMS

This section provides information about the appeals processes in each state. The *General Information and Internal Plan Review* section for each state includes basic information about the state's appeal procedures and state requirements that health plans must follow for internal appeals. The external review procedures for the states are shown in tables that present an outline of the state's process and contact information, current as of August 2004. Notice that states typically require you to go through your health plan's internal appeal process before you can begin the external review process. If you have questions, call the state agency or go to the state web site listed at the bottom of each state's table.

If you have an employer-sponsored health plan, federal law may provide you with additional or alternative appeal rights. Federal law requires that employer-sponsored health plans must have internal appeal processes that meet federal standards. These federal requirements may add to the rights that you have under state law. To learn more about federal internal appeal procedures for employer-sponsored plans, contact the Department of Labor's Employee Benefits Security Administration (EBSA) by calling 1-866-444-3272, or locate an EBSA regional office at http://www.dol.gov/ebsa/aboutebsa/org_chart.html#section13. If you are covered through an employer-sponsored health plan that is self-funded, you generally will not be entitled to use your state's external review process. Check with your state or with the Department of Labor to be sure.

Alabama

As of January 1, 2005, Alabama did not have an external review program for denials of coverage for services that health plans consider either experimental or not medically necessary. Alabama does provide administrative review of disputes through the Department of Public Health.

How to Get More Information:

- Contact your health plan.
- Alabama Department of Public Health, 334-206-5300

Alaska

General Information and Internal Plan Review:

Unlike other states, the Alaska Division of Insurance does not have a direct role in the external appeal process.

The External Appeal Process:

Whom to contact:	Your health plan
Who can appeal:	You or your health plan
What you can appeal:	1. Denials of coverage for services the health plan determines are not medically necessary or are experimental or investigational, or 2. Denials of coverage when medical judgment is needed to determine whether or not the service is a covered benefit under the plan, or 3. Denials of coverage based on failure to meet your health plan's internal appeal deadlines.
When you can appeal:	You must make a "timely appeal" in writing.
What to send:	You are allowed to submit evidence related to the issues in dispute. The law requires the External Appeal Agency to consider: 1. The standards and guidelines used to make the decision, 2. Pertinent personal health or medical information, 3. Your provider's opinion, 4. The group health insurance plan The external appeal agency may also consider: 1. Reliable and valid studies, 2. Government conducted or financed professional conference results, 3. Government treatment and practice guidelines, 4. Government coverage and treatment policies, 5. Generally accepted principals of medical practice, 6. Expert opinions, 7. Peer reviews, 8. Community standard of care, 9. Anomalous utilization patterns.
What you must pay:	Charges incurred by you or your physician in support of the external appeal.

What will happen:	The External Appeal Agency will make a decision and supply the decision in writing to you and your health plan as soon as possible.
When you will get a decision:	No later than 21 working days after the appeal is filed.
In urgent situations:	An expedited review will be completed within 72 hours after the request for an external appeal.

How to Get More Information:

Contact your health plan.

Information updated as of 1-14-2004

Arizona

General Information and Internal Plan Review:

Arizona distinguishes between “denied services" (care you have yet to receive) and "denied claims" (for care you have already received). To appeal either, you must start with an internal appeal. For denied services, you must request an Informal Reconsideration (or, if urgent, an Expedited Medical Review). For denied claims, your insurer may allow you to begin with the Informal Reconsideration or may require you to initiate a Formal Appeal.

If the insurer continues to deny your request, you may file a Formal Appeal with the insurer within 60 days of the completion of the Informal Reconsideration of a denied service or up to two years after a denied claim. The insurer has 30 days to make a decision on denied services and 60 days for denied claims. If the Formal Appeal is denied, you have 30 days to request an External, Independent Review.

The External, Independent Review Process:

Whom to contact:	Your health plan
Who can appeal:	You, your provider, or your authorized representative
What you can appeal:	Denied claims or denied requests for services
When you can appeal:	You must appeal within 30 days after receiving notification of denied Formal Appeal or within 5 days after an expedited appeal denial.
What to send:	Either write a letter or use the request form provided in your health plan’s information packet and include any relevant materials to support your case. You are not required to use the form.
What you must pay:	No charge
What will happen:	The insurer will send a copy of the policy, medical records, all documents used to render the decision, and a description of the issues and the basis for the decision to the state Department of Insurance (DOI). For denials based on a coverage issue: 1. Within 15 days of receiving the information, the DOI will review and determine if the service or claim is covered under the policy. 2. The DOI will mail a notice of the decision to you, your health plan, and your treating provider. 3. If the DOI cannot make a decision, it may refer the case to an independent review organization. For denials based on medical necessity: 1. Within 5 days of receiving the information, the DOI will send your case to an independent review organization (IRO).

	2. The independent reviewer will evaluate the case, make a decision within 21 days, and send a notice of the decision to the DOI. 3. Within 5 business days of receiving the IRO's decision, the DOI will send a notice to you, your health plan, and your treating provider.
When you will get a decision:	For standard reviews based on coverage issues: within 20 business days from the date your request is received. For standard reviews based on medical necessity: approximately 36 days from the date your request is received.
In urgent situations:	To be eligible for the three-tiered expedited appeal process, your treating provider must submit a written certification to your insurer and send supporting documentation indicating that waiting through the standard appeal process is likely to cause a significant negative change in your medical condition at issue. After you have completed 2 internal expedited levels of review, you may request expedited external review, which will be completed within 3 business days (for coverage issues) or 9 business days (for medical necessity issues).

How to Get More Information:

Arizona Department of Insurance, 800-325-2548 (statewide)
www.id.state.az.us/consumermore.html

Information updated as of 2-12-2004

Arkansas

General Information and Internal Plan Review:

Arkansas' external review process applies to all "health benefit plans," which includes managed care plans such as PPOs and HMOs, BCBS plans, and traditional indemnity insurers. An "adverse determination" is the determination by the health plan that it will not pay for a requested service, while a "final adverse determination" is a similar determination made after you have appealed the adverse determination through the health plan's internal review process.

Timelines may vary depending upon whether the service in dispute is considered a pre-service claim or a post-service claim. A service which your health plan must approve before you receive it in order for you to be eligible for coverage is considered a pre-service claim. All other services are post-service claims.

If your appeal is denied, your health plan will tell you how to file for an independent external review. Independent Review Organizations (IROs) are selected from a list of organizations approved by the state.

The External Review Process:

Whom to contact:	Your health plan
Who can appeal:	You or your authorized representative. If you are unable to provide consent, a family member may be considered your authorized representative, or if a family member is not available, your health care provider may be considered your authorized representative.
What you can appeal:	Denial, reduction, or termination of payment for services that the health plan determines are not medically necessary or are experimental. The cost to the health plan for the services in dispute must be at least $500.
When you can appeal:	In most cases, you may apply for external review after the adverse decision has been appealed through all levels of the health plan's internal process within 60 days from receipt of the final adverse determination. You may file for external review without having appealed through all levels of your health plan's internal process if either your health plan agrees or if your health plan has not issued a written decision to your internal appeal within 30 days of filing a pre-service claim or within 60 days of filing a post-service claim.
What to send:	A request in writing (may be submitted by fax or email)
What you must pay:	$25 (This fee can be waived by the Commissioner if you show evidence of financial hardship.)

What will happen:	1. The health plan assigns your case to an Independent Review Organization (IRO). 2. The IRO conducts a preliminary review within 5 days to assure that your case meets requirements and includes all necessary information. 3. If your request is not complete, you, your provider, and your health plan will be notified about what information or materials are still needed. 4. You, your provider, or the health plan may provide additional documentation and information to the IRO within 7 business days of receiving notification by the IRO. 5. The reviewer makes a decision and notifies you, your provider, and the health plan.
When you will get a decision:	Within 45 calendar days after receiving your request for external review.
In urgent situations:	You can get an expedited review within 72 hours in three situations: 1. Delay will seriously jeopardize your life or health. 2. You have received emergency services but not yet been discharged from the facility. 3. The services in dispute are experimental or investigational and your provider certifies that treatment will be significantly less effective if not promptly started.

How to Get More Information:

Arkansas Insurance Department, Consumer Services Division, (501) 371-2640 or 1-800-852-5494

Information updated as of 2-7-2005

California

General Information and Internal Plan Review:

California's Department of Managed Health Care provides a 24-hour-a-day, seven-day-a-week HMO Help Center. The HMO Help Center administers the independent medical review program. Applications for Independent Medical Review (IMR) are submitted directly to the HMO Help Center. If eligible for review, cases are decided by an accredited review organization performing services under a state contract. The Department adopts the IMR decisions, which are binding on the health plan or HMO. The Department resolves problems for commercial as well as Medi-Cal (Medicaid) HMO enrollees.

The California Department of Insurance also receives and process applications for IMR with substantially the same application and review process for decisions made by health insurance companies.

The Complaint Resolution and Independent Medical Review Process:

Whom to contact:	California Department of Managed Health Care's HMO Help Center (or the Department of Insurance, depending on the type of coverage you have).
Who can appeal:	You, your provider (with consent), or your authorized representative
What you can appeal:	An HMO's or health plan's decision, including ones regarding experimental or investigational treatment and disputed medical necessity services.
When you can appeal:	A review must be requested within 6 months of when requested care was denied or grievance determination, whichever is later.
What to send:	An application for IMR or the equivalent information with the patient's authorization to release medical records and information. Call the HMO Help Center for more information or obtain forms at http://www.dmhc.ca.gov/imr/forms/
What you must pay:	No charge
What will happen:	The California HMO Help Center will: 1. Determine what the best course of action is for your complaint, including Independent Medical Review. If you qualify for Independent Medical Review, you will: 2. Be notified that the case has been accepted. 3. Have an opportunity to submit supporting information to the review. (The health plan will submit all medical records in its possession to the assigned review organization - you may but are not required to provide additional medical records.) 4. Receive a written analysis and determination, adopted by the Department.
When you will get a decision:	Usually within 30 days
In urgent situations:	Call the Department's HMO Help Center for emergency or urgent situations.

How to Get More Information:

- California Department of Managed Health Care, www.hmohelp.ca.gov
- California HMO Help Center, 888-HMO-2219, TDD 877-688-8981, Fax 916-229-4326
- California Department of Insurance, www.insurance.ca.gov/docs/FS-Consumer.htm

Information updated as of 9-15-2004

Colorado

General Information and Internal Plan Review:

Colorado specifies two levels of internal review, but the health plan may choose to skip the first level and handle appeals at the second level. If applicable, the first level appeal must be completed within 20 days of the request (72 hours for an expedited review). At the second level, the health plan's appeal panel must meet within 45 days of the request (for both standard and expedited reviews) and produce a decision within 5 days of the meeting. You have a right to appear in person or by conference call or video conferencing at the panel meeting. If your appeal is denied, your health plan will tell you how to file for an independent external review.

The Independent External Review Process:

Whom to contact:	Your health plan
Who can appeal:	You, your provider (with consent), or your authorized representative
What you can appeal:	Denials of coverage for services the health plan determines are not medically necessary or are experimental.
When you can appeal:	After denial for coverage has been appealed through all levels of the health plan's internal process, you must appeal within 60 days from receipt of the final adverse determination.
What to send:	A completed request form
What you must pay:	No charge
What will happen:	1. Health plan notifies the insurance department by fax that you have requested an external review. 2. The insurance department assigns an independent external reviewer. 3. The health plan sends all relevant information to the reviewer. The reviewer may request additional information from you, your doctor, or your health plan. 4. The reviewer makes a decision and notifies you, your health plan, and the department of insurance.
When you will get a decision:	Within 30 working days (the deadline may be extended 10 additional working days if additional information needs to be considered).
In urgent situations:	If a delay will jeopardize your health (you must have your doctor's certification), you can get an expedited review within 7 days. This can be extended 5 more days if the reviewer needs more time.

How to Get More Information:

Colorado Division of Insurance 303-894-7490
www.dora.state.co.us/insurance/

Information updated as of 9-8-2004

Connecticut

General Information and Internal Plan Review:

Connecticut requires you to exhaust all internal appeal procedures at your plan or its utilization review company before you begin the external appeal process.

The External Appeal Process:

Whom to contact:	Connecticut Insurance Department
Who can appeal:	You, your provider (with your written consent), or your legal representative
What you can appeal:	Denials of coverage for services covered in your contract that your health plan determines are not medically necessary. An appeal may be filed before, during, or after the service in dispute is provided.
When you can appeal:	After denial for coverage has been appealed through all levels of the health plan's internal process, you must appeal within 30 days from receipt of the final denial letter from the health plan.
What to send:	1. A completed "Request for External Appeal" form (available from the Insurance Dept). 2. Evidence of enrollment (such as a photocopy of your insurance card) 3. Copies of all pertinent correspondence 4. Copy of letter saying all internal appeals have been exhausted 5. Copy of certificate of coverage 6. Filing fee
What you must pay:	$25 (the fee is waived under certain conditions)
What will happen:	1. The Insurance Department will assign the appeal to an external review agent. 2. The external review agent will conduct a preliminary review to determine if the request is eligible for full review. 3. If the request is eligible, the external review agent will notify you, or your provider, and the plan of the opportunity to submit additional information within 5 business days. The external review agent will complete a full review and notify the Insurance Dept. of its decision. 4. The Insurance Dept. will notify you, your doctor, the plan, and the utilization review company.

When you will get a decision:	Preliminary review: A decision is provided to the Insurance Commissioner 5 business days after receipt of appeal. The Insurance Commissioner reviews the decision and notifies all parties. Full review: A decision is provided to the Insurance Commissioner 30 business days after completion of the preliminary review. The Insurance Commissioner reviews the decision and notifies all parties.
In urgent situations:	No expedited external appeal process

How to Get More Information:

State of Connecticut Insurance Department, 800-203-3447 (in-state only)
www.state.ct.us/cid/

Information updated as of 7-16-2004

Delaware

General Information and Internal Plan Review:

For managed care organizations, regulated by both the Department of Health and Social Service and the Department of Insurance, Delaware specifies 2 stages of internal review for health plans. Stage 1 must be completed within 5 days, and stage 2 must be completed within 30 days. For conditions that cause an imminent, emergent, or serious threat to the health of the enrollee, each stage may take no more than 72 hours. If the appeal concerns an "Emergency Medical Condition" (which is defined by health department regulations), both stages must be concluded within 72 hours. If you receive an adverse determination after the internal reviews, then you can apply for the independent health care appeals program.

Enrollees of commercial plans regulated by the Delaware Department of Insurance (excluding self-funded ERISA and governmental plans) can also access the Independent Health Care Appeals Process after an internal review procedure by the carrier.

The Independent Health Care Appeals Process:

Whom to contact:	Your health plan
Who can appeal:	You or your authorized representative
What you can appeal:	Denial, reduction, or termination of health care benefits that deprive the covered person of medically necessary covered services.
When you can appeal:	You must file within 60 days after you receive notice of an adverse determination from your health plan.
What to send:	A written request: 1. Your name & address 2. Your health plan information 3. A brief request for review by IHCAP (Independent Health Care Appeals Program) There is no restriction on the amount of material you may supply to the Independent Utilization Review Organization (IURO), but it must be supplied within 7 days of the IURO's notification of acceptance.
What you must pay:	No charge
What will happen:	1. Your health plan will notify the Department of Health and Social Services (DHSS) 2. DHSS will assign an Independent Utilization Review Organization (IURO). 3. The IURO will review the case and make its determination as appropriate. 4. The IURO will make a decision and notify you.

When you will get a decision:	45 days after receipt of a completed application for appeal review
In urgent situations:	If your case involves an imminent, emergent, or serious threat to the health of the enrollee or if immediate medical attention is required, the appeal process will not exceed 72 hours.

How to Get More Information:

Delaware Office of Health Facilities Licensing and Certification, 800-942-7373 or 302-995-8521

Information updated as of 7-16-2004

District of Columbia

General Information and Internal Plan Review:

The District of Columbia sets out 3 separate levels of grievance appeals: informal internal review by the insurer, formal review by the insurer, and formal external review by an independent review organization.

Informal internal appeals are to be completed within 14 business days, and within 24 hours for urgent or emergency care. Formal internal appeals are to be completed within 30 business days, and within 24 hours for urgent or emergency care.

The Formal External Review Process:

Whom to contact:	Director of the District of Columbia Department of Health
Who can appeal:	You, your provider (with consent), or your authorized representative
What you can appeal:	Denial, reduction, limitation, termination, or other delay of covered health care services.
When you can appeal:	After denial for coverage has been appealed through the health plan's formal internal process, you must file within 30 days from receipt of the written decision of the health plan. If the health plan fails to meet the deadlines for completing a formal internal appeal, the member may begin the external process without waiting for the health plan's decision.
What to send:	1. Written request for appeal 2. Completed medical record consent form 3. Final decision of health plan
What you must pay:	No charge
What will happen:	The Director will: 1. Evaluate the appeal for processing (is the complainant a member, are the requested services covered benefits, is all information available, etc.) 2. Notify you whether the appeal is eligible for processing 3. If acceptable, assign the appeal on a rotating basis to an independent review organization. The independent review organization will: 1. Conduct a full review by at least 2 physicians. Either you or a health plan representative may request to appear in person at a hearing by the review organization.

When you will get a decision:	Within 30 business days from the time the independent review organization is assigned.
In urgent situations:	You may be able to start the appeals process before completing the informal and formal urgent appeals in cases of emergency or urgent care. An expedited appeal will be completed within 72 hours from the time the independent review organization is assigned.

How to Get More Information:

District of Columbia Department of Health, www.dchealth.dc.gov
Grievance and Appeals Coordinator, 202-442-5979

Information updated as of 2-7-2005

Florida

General Information and Internal Plan Review:

Florida requires health plans to address problems through their internal grievance procedure before seeking resolution through the Subscriber Assistance Program. By law the internal grievance process should require no more than 60-90 days to complete. After completing the internal process, you are eligible to file a grievance with the Subscriber Assistance Program.

The External Appeal Process:

Who to contact:	Subscriber Assistance Program (SAP)
Who can appeal:	You, your provider (on your behalf), or your authorized representative
What you can appeal:	Denials of coverage for services the health plan determines are not medically necessary or are experimental or investigational, non-authorization or denial of services you believe are covered by the plan, out of network requests.
When you can appeal:	You must file only after completing all levels of the health plan's internal grievance procedure. You must file within 365 days of receiving the notice of final denial.
What to send:	A completed "Request for Review and Release Form"
What you must pay:	No charge
What will happen:	1. You send the release form and supporting information. 2. The health plan submits pertinent information. 3. The SAP analyst determines whether the case is one over which the program has jurisdiction. 4. The SAP analyst prepares the information for a hearing. 5. A hearing is scheduled. 6. You and your health plan will participate by telephone conferencing with the SAP panel. You and your health plan will each have 15 minutes to present your case, and 5 minutes of rebuttal, if necessary. 7. The SAP panel will evaluate the case and prepare a written recommendation within 15 working days, unless more time is needed to gather necessary information requested by the panel. 8. You and your health plan have 10 days after receiving the recommendation to submit written objections.

	9. The Agency or the Department of Finance, Office of Insurance Regulation, depending upon which department has jurisdiction in the case, will make a final determination. The final Proposed Order will be sent to you. 10. The health plan has 30 days to comply if the final order is in your favor.
When you will get a decision:	Within 165 days
In urgent situations:	An expedited review is available for cases in which there is a serious threat to continued health. An expedited review is scheduled for hearing within 45 days and resolved within 65 days. If there is an impending threat of death, an emergency case is heard within 24 hours.

How to Get More Information:

For quality of care:
Agency for Health Care Administration, 888-419-3456
http://www.fdhc.state.fl.us/MCHQ/Consumer/SPSAP/index.shtml

For billing or enrollment problems:
Insurance Consumer Helpline, 800-342-2762

Information updated as of 9-29-2004

Georgia

General Information and Internal Plan Review:

Georgia health plans must have internal review processes. If you have exhausted your health plan's internal appeals, you may apply for external review.

The Independent Review Process:

Whom to contact:	Office of General Counsel, Division of Health Planning
Who can appeal:	Enrollee or an eligible dependent of an enrollee of a managed care plan
What you can appeal:	Health plan denials of treatment for services that cost more than $500 and either appear to be covered services or are experimental treatments for patients with terminal conditions.
When you can appeal:	You must file after you have received a final notice of adverse outcome from your health plan after exhausting all levels of appeals within your health plan's internal review process.
What to send:	1. A completed Request Form (located on the Division of Health website). 2. Total cost or estimate of procedure or service. 3. Copies of all denial letters from the provider.
What you must pay:	No charge
What will happen:	The Division of Health Planning will: 1. Notify you in writing that your request was received. 2. Determine if you are an eligible enrollee. 3. Randomly assign your case to an independent review organization and provide you with its name and address. You or the health plan may be required to provide more information or documents within 5 days (although you may request an extension to 10 days). The independent review organization will: 1. Review your case. 2. Made a determination in writing.
When you will get a decision:	15 days after the "additional information" deadline

In urgent situations:	If the standard time frame would jeopardize your health, life, or ability to regain maximum function, an expedited review may provide a decision with 72 hours after the reviewer receives all requested documents.

How to Get More Information:

Georgia Department of Community Health, Office of General Counsel, Division of Health Planning, Kimberly Anderson 404-657-4563
www.communityhealth.state.ga.us/

Information updated as of 2-17-2005

Hawaii

General Information and Internal Plan Review:

Hawaii requires health plans to establish internal review procedures that provide a decision within 60 days, or within 72 hours if medical circumstances require an expedited review. The response from the health plan will explain how to apply for external review. You must exhaust the health plan's internal review process prior to filing a request for external review.

The External Review Process:

Whom to contact:	The Hawaii Insurance Division – Health Insurance Branch
Who can appeal:	You, your provider (with consent), or your authorized representative
What you can appeal:	Denials of coverage or payment for services the health plan determines are not medically necessary or are experimental or investigational.
When you can appeal:	The written request must be received within 60 days of the date of the health plan's final internal determination.
What to send:	A written request for review
What you must pay:	No charge
What will happen:	1. Your health plan will send any documents to the reviewer within 7 days of notification (within 48 hours for an expedited review). 2. The insurance commissioner will appoint a 3-member review panel. 3. For disputes involving less than $500, the insurance commissioner may conduct a review without appointing a review panel. 4. A review hearing will be conducted within 60 days of the original request. 5. The review panel will decide whether your health plan acted reasonably by a majority vote. 6. The commissioner of insurance will issue an order affirming, modifying, or reversing the health plan's decision within 30 days of the hearing.
When you will get a decision:	Within 90 days of the request for review
In urgent situations:	For an expedited review, the health plan must send documents within 48 hours and the review must be completed within 72 hours.

How to Get More Information:

Hawaii Department of Commerce and Consumer Affairs, Insurance Division, Health Insurance Branch, 808-586-2804
www.state.hi.us/dcca/ins/

Information updated as of 9-14-2004

Idaho

As of January 1, 2005, Idaho did not have an external review program for denials of coverage for services that health plans consider either experimental or not medically necessary.

How to Get More Information:

Contact your health plan.

Illinois

General Information and Internal Plan Review:

Illinois requires health plans (HMOs) to follow an internal appeal procedure that requests the necessary information within 3 days of receiving the appeal, and to provide a decision within 15 business days after receiving the information. If your medical situation requires an expedited review, the health plan must request the information within 24 hours and provide a decision within 24 hours after receiving the information. If your request is denied, you may request external review from your health plan. You may also file a complaint at any time with the Illinois Department of Financial and Professional Regulation – Division of Insurance.

The External Independent Review Process:

Whom to contact:	Your health plan
Who can appeal:	You, your provider (with consent), or your authorized representative
What you can appeal:	Denials or limitations of coverage for health care services your health plan considers are not medically appropriate.
When you can appeal:	After completing all levels of your health plan's internal appeal procedure, you must file within 30 days of receiving written notice of an adverse determination.
What to send:	A written request, including necessary information or documentation to support your request
What you must pay:	No charge
What will happen:	1. Your health plan will provide for selection of an external independent reviewer jointly by you, your provider, and the health plan. 2. Your health plan will provide all documentation to the reviewer. 3. The reviewer will make a decision within 5 days of receiving all information.
When you will get a decision:	In general, 35 days after your health plan receives the request for external review.
In urgent situations:	An expedited review is available if denial of the service could significantly increase the risk to your health; a decision will be made within 24 hours of receiving all necessary information.

How to Get More Information:

Illinois Financial and Professional Regulation – Division of Insurance,
217-558-2309
www.idfpr.com

Information updated as of 7-15-2005

Indiana

General Information and Internal Plan Review:

Health plans' internal appeals must meet regulatory guidelines and be approved by the Department of Insurance annually. After you have completed all levels of the internal process, you may file for external review.

The External Review Process:

Whom to contact:	Your health plan
Who can appeal:	You or your authorized representative
What you can appeal:	Denials or limitations of coverage for services the health plan determines are not appropriate, medically necessary, or are experimental or investigational.
When you can appeal:	After denial for coverage has been appealed through all levels of the health plan's internal process, you must file within 45 days from receipt of the final adverse determination.
What to send:	A written request for external review
What you must pay:	The health plan may charge you up to $25 towards the cost of the review.
What will happen:	1. The plan selects an independent review organization for your case on a rotating basis and sends pertinent information. 2. The reviewer may ask for additional information. 3. The reviewer will notify you and your health plan of the decision.
When you will get a decision:	Within 15 business days of filing for review. The reviewer has an additional 72 hours to notify you of this decision.
In urgent situations:	If a delay will seriously jeopardize your health, life, or ability to regain maximum function, an expedited review can be completed within 72 hours of filing. The reviewer has an additional 24 hours to notify you of this decision.

How to Get More Information:

Indiana Department of Insurance, Consumer Services, 800-622-4461 (in-state) or 317-232-2395
www.state.in.us/idoi

Information updated as of 2-24-2005

Iowa

General Information and Internal Plan Review:

Iowa has no state requirements for a health plan's internal review procedure.

The External Review Process:

Whom to contact:	Iowa Insurance Division
Who can appeal:	You or your provider (with consent)
What you can appeal:	Denials for medical service claims your health plan believes are not medically necessary.
When you can appeal:	After denial for coverage has been appealed through all levels of the health plan's internal process, you must file within 60 days of the denial.
What to send:	1. A letter detailing why you are requesting the review and providing a return address and day-time phone number for both you and your provider. 2. A photocopy of the letter denying coverage from your health plan. 3. The $25 filing fee.
What you must pay:	$25 (The fee will be refunded if the decision is in your favor, or the fee may be waived by the Commissioner).
What will happen:	The health plan will select an independent review agent from a list approved by the insurance department.
When you will get a decision:	Approximately 35 days for an uncontested review and 45 days for a contested review
In urgent situations:	If a delay would jeopardize your health, an expedited review may be requested and a decision will be delivered within 72 hours

How to Get More Information:

Iowa Insurance Division, 877-955-1212
www.iid.state.ia.us

Information updated as of 9-13-2005

Kansas

General Information and Internal Plan Review:

Kansas requires health plans to have and disclose their internal grievance procedures to their members. If your request for services is turned down, you will receive an adverse determination letter from your health plan. If a final decision has not been made within 60 days (unless the delay was due to your request), you may file for independent medical review.

The Independent Medical Review Process:

Whom to contact:	Kansas Insurance Commissioner
Who can appeal:	You, your provider (with consent), or your authorized representative
What you can appeal:	Denials of coverage for services the health plan determines are not medically necessary or are experimental or investigational.
When you can appeal:	After denial for coverage has been appealed through all levels of the health plan's internal process (except for an expedited appeal), you must file within 90 days from the adverse determination.
What to send:	A completed form, which includes a medical records release. You should also write a letter summarizing your situation and providing as much information as possible, including any medical literature that supports your case.
What you must pay:	No charge
What will happen:	1. The Insurance Commissioner reviews the case within 10 days to determine if it qualifies for review. 2. If the case is accepted, it is sent to the external review organization. 3. You and your health plan have 7 days to provide additional information. 4. The case is assigned to a physician. 5. The review organization notifies you, your health plan, and the Insurance Commissioner of the decision.
When you will get a decision:	Within 30 business days after submitting your request
In urgent situations:	An expedited review is available for an emergency medical condition; the case is immediately evaluated and sent to the review organization, you have 5 days to provide additional information, and a decision will be made within 7 business days.

How to Get More Information:

Kansas Insurance Department, 800-432-2484 (in-state)
www.ksinsurance.org

Information updated as of 9-15-2004

Kentucky

General Information and Internal Plan Review:

Kentucky categorizes health plan refusals for service as either coverage denials or adverse determinations. A coverage denial involves services, treatments, drugs, or devices that the health plan claims are not covered by the health plan contract. An adverse determination involves services, treatments, drugs, or devices that the health plan claims are not medically necessary or appropriate, or are experimental or investigational. If you receive either a "notice of coverage denial" or a "denial letter of adverse determination," you are eligible to ask the health plan for an internal appeal which will be completed within 30 days of the request (or within 3 business days of the request if you are hospitalized or a treating physician states that a review under the standard time frame could jeopardize your health).

If you are not satisfied with the result of appealing a coverage denial, you can write the Department of Insurance and request a coverage denial review. If the coverage denial requires resolution of a medical issue, the Department may require your health plan to allow you an external review.

If you are not satisfied with the result of appealing a denial letter of adverse determination, you can contact your health plan and request an external review.

The External Review of Adverse Determination Process:

Whom to contact:	Your health plan
Who can appeal:	You, your provider (with consent and authorization), or your authorized representative
What you can appeal:	Adverse determinations: services, treatments, drugs, or devices that the health plan claims are not medically necessary or appropriate, or are experimental or investigational, for services that would have cost you at least $100 if you had no insurance.
When you can appeal:	After you exhaust the health plan's internal appeal process, or if you and your health plan agree to waive the internal appeal process, you must file within 60 days after receipt of an adverse determination.
What to send:	Written request, medical records release, and written designation/authorization of person or provider, if applicable.
What you must pay:	$25 filing fee payable to the independent review entity (may be refunded if the decision is in your favor, or may be waived for financial hardship).

What will happen:	1. Your health plan will determine whether or not to grant an external review based upon established criteria and arrange the external review, if indicated. 2. If you are not granted a review, you may file a written complaint with the Department of Insurance and the Department will decide whether or not you will receive an external review within 5 days. 3. If you are granted an external review, an independent review entity will be assigned to your case. 4. The independent review entity decides your case.
When you will get a decision:	Within 21 days (unless you and your health plan agree to an additional 14-day extension)
In urgent situations:	If you are in the hospital or your treating physician states that an external review under the 21-day time frame could jeopardize your health, a determination will be made in 24 hours (unless you and your health plan agree to an additional 24-hour extension).

How to Get More Information:

Kentucky Department of Insurance, 800-595-6053 or 800-462-2081 (Hearing Impaired)
www.doi.state.ky.us

Information updated as of 8-30-2004

Louisiana

General Information and Internal Plan Review:

Louisiana requires health plans to be authorized as Medical Necessity Review Organizations (MNRO) or to use an approved MNRO to make medical determinations about the appropriateness of care. If your request is denied, your provider may ask for an informal reconsideration of the decision. If you receive an adverse determination, Louisiana provides for both a first level internal appeal and a second level review process. In the second level review process, you have the right to discuss your situation in person. If your second level review upholds the adverse determination, you can request an external review. If a delay will seriously jeopardize your life, health, or ability to regain maximum function, an expedited appeal is available. It is possible that your health plan has an approved internal procedure that allows you to begin the external review process without completing a second level review, or will agree to waive requirements for the internal appeal or review.

The External Review Process:

Whom to contact:	The Medical Necessity Review Organization (MNRO)
Who can appeal:	You, your provider (with consent), or your authorized representative
What you can appeal:	Denials of coverage for services the health plan determines are not medically necessary.
When you can appeal:	After denial for coverage has been appealed through all the levels of the health plan's internal process, you must file within 60 days from receipt of the second level appeal adverse determination.
What to send:	File a request with the MNRO
What you must pay:	No charge
What will happen:	1. The MNRO will send all pertinent information to its designated independent review organization within 7 days of the request. 2. The review organization will evaluate the information and respond with a recommendation to you, the MNRO, and your provider.
When you will get a decision:	Within 30 days after receiving the necessary information, unless everyone involved agrees to a longer period.
In urgent situations:	If you receive an adverse determination involving an emergency medical condition while being treated in an emergency room, during hospital observation, or as a hospital inpatient, your provider may request an expedited review. A decision will be made and you will be notified within 72 hours after the review organization receives the necessary medical information.

How to Get More Information:

Louisiana Department of Insurance Help Desk, 800-259-5300 or 225-219-4770
www.ldi.la.gov/consumers/misc_pubs/MNRO%20brochure.pdf

Information updated as of 10-25-2004

Maine

General Information and Internal Plan Review:

If your health plan gives you an adverse determination on an initial request for services, Maine allows your provider to request an informal reconsideration. If this does not resolve the difference of opinion, Maine provides for two levels of internal appeal. At the first level appeal, a decision is due within 20 working days of the request for review, unless that time frame cannot be reasonably met. For an expedited appeal, a response is due within 72 hours after the review is initiated. If the first level appeal does not resolve the differences, a second level appeal is available. If you are still denied coverage after a second level appeal, you can request an independent external review.

The Independent External Review Process:

Whom to contact:	Maine Bureau of Insurance, Consumer Health Care Division
Who can appeal:	You, your provider (with consent), or your authorized representative
What you can appeal:	Denials of coverage for services the health plan determines are not medically necessary, are experimental or investigational, or are based on pre-existing condition exclusions.
When you can appeal:	You must file within 12 months from receipt of the final adverse health care treatment decision. Although you must usually exhaust all levels of the health plan's internal process, this is not required if: 1. The internal grievance is not resolved in the required time period, 2. You and your health plan agree to bypass the internal procedure, 3. Your life or health is in serious jeopardy, or 4. You have died.
What to send:	A written request to the Maine Bureau of Insurance, Consumer Health Care Division
What you must pay:	No charge
What will happen:	1. The Bureau of Insurance sends your request to a contracted independent review organization. 2. You have the right to request a hearing (telephone conference). 3. The health plan has to send all pertinent records to you and the review organization. 4. You may submit additional information to the review organization. (who will send copies of that information to your health plan). 5. The review organization will make a decision and notify you, your health plan, and the Bureau of Insurance.

When you will get a decision:	Within 30 days of the date the case is received by the external review organization
In urgent situations:	If delay will seriously jeopardize your life, health or ability to regain maximum function, the decision must be made within 72 hours of the request for review.

How to Get More Information:

Maine Bureau of Insurance, 800-300-5000 (in Maine)
www.maineinsurancereg.org

Information updated as of 9-28-2004

Maryland

General Information and Internal Plan Review:

Maryland requires health plans to establish an internal grievance process that provides a response within 30 working days of filing for most situations, within 24 hours for emergencies, and within 45 working days when the services have already been provided. If you receive an adverse decision, you may file a complaint for review of the grievance decision. You must first, however, exhaust the health plan's internal grievance process.

The Appeal Process:

Whom to contact:	Maryland Insurance Administration (MIA)
Who can appeal:	You, your provider (with consent), or your health plan
What you can appeal:	Denials of coverage for services the health plan determines are not medically necessary or are experimental or investigational. There is also a separate appeals process for coverage decisions.
When you can appeal:	After denial for medical necessity has been appealed through the health plan's internal process, you must file within 30 working days from receipt of the final adverse determination. If there is a compelling reason as determined by the MIA, you may go directly to the MIA. After denial of a coverage decision has been appealed through the health plan's internal process, you must file within 60 working days from receipt of the final appeal decision, except for an urgent medical condition.
What to send:	A written appeals and grievances complaint, including copies of all relevant documentation, such as the denial letter from the health plan and pertinent medical records.
What you must pay:	No charge
What will happen:	For a medical necessity appeal: 1. The MIA will notify your health plan within 5 working days after receiving your request. 2. Your health plan will provide all pertinent information within 7 working days of notification. 3. The MIA may seek advice from an independent review organization. 4. The MIA will investigate your case and return a final decision.

When you will get a decision:	For medical necessity: Within 30 working days of filing a complaint with the MIA if the service has not been provided; within 45 working days if the service has already been provided. The deadline may be extended up to an additional 30 working days if the pertinent information has not been received or it is necessary. For coverage decisions: The time requirement for investigation may vary.
In urgent situations:	For expedited reviews you will receive a response within 24 hours. If your appeal "involves compelling circumstances" you may skip the health plan's internal process and file directly with the MIA.

How to Get More Information:

Maryland Insurance Information, 800-492-6116 (800-735-2258 TTY)
For help in filing appeals forms, call the Attorney General Health Education and Advocacy Unit, 877-261-8807

Complaint form and medical release forms are available on the web site under Consumer Information. www.mdinsurance.state.md.us

Information updated as of 9-13-2004

Massachusetts

General Information and Internal Plan Review:

Massachusetts' external review process applies to any fully insured Massachusetts-based health plan. First file an internal grievance through your health plan, which the plan must resolve within 30 business days of receiving all necessary information unless you agree to extend the time frame. If the plan does not respond within 30 days, the services are automatically covered. An expedited appeal process is also available for immediate and urgently needed services. If you receive written notice of a final adverse determination from the health plan, you may file for external review.

The External Review Process:

Whom to contact:	Office of Patient Protection, Massachusetts Department of Public Health
Who can appeal:	You, your provider (with consent), or your authorized representative
What you can appeal:	Any denial of a medically necessary service covered by the health plan.
When you can appeal:	You must file within 45 days of receipt of your health plan's final adverse determination letter.
What to send:	Follow the procedures provided by your health plan or request an external review application from the Office of Patient Protection.
What you must pay:	$25 (may be waived for financial hardship)
What will happen:	The Department of Public Health will randomly assign your case to an external review agency. The review agency will evaluate the case and return a decision.
When you will get a decision:	Usually within 60 business days after the review agency receives the request from the Department of Public Health, although the review agency may request an additional 15 business days.
In urgent situations:	To be eligible for the expedited appeal process, your treating provider must submit a written certification to your insurer and send supporting documentation indicating that waiting through the standard appeal process is likely to cause a substantial risk of serious harm to the patient. After you have completed the internal expedited levels of review, the expedited external review will be completed within 5 business days.

How to Get More Information:

Office of Patient Protection, 800-436-7757 or fax 617-624-5046
www.state.ma.us/dph/opp/
Included within the Office of Patient Protection is the Office of the Managed Care Ombudsman, which is available to assist health plan members with questions and concerns regarding managed care, grievances, appeals, denials of care, continuity of care, and independent external reviews. Call 1-800-436-7757.

Information updated as of 2-10-2005

Michigan

General Information and Internal Plan Review:

Michigan law requires you to complete an internal review with your health plan prior to using the external review. The health plan is required to give you a final decision within 35 days and will provide an Office of Financial and Insurance Services (OFIS) Health Care Request for external review form. The health plan may extend this time frame an additional 10 business days if they need additional information from the health care facility or health provider. If your health plan does not provide a decision within the required time frame, you may file for External Review without the notice of final adverse determination.

The External Review Process:

Whom to contact:	Michigan Office of Financial and Insurance Services (OFIS)
Who can appeal:	You or your authorized representative
What you can appeal:	The availability, delivery, or quality of health care services, including a complaint regarding an adverse determination, benefits or claims payment, handling or reimbursement for health care services, as well as issues concerning the contract between you and your health plan.
When you can appeal:	After denial for coverage has been appealed through the health plan's internal process, you must file not later than 60 days from receipt of a notice of final adverse determination.
What to send:	1. Completed OFIS Health Care Request for External Review form 2. Copy of the written final adverse determination from your health plan 3. Any additional supporting information.
What you must pay:	No charge
What will happen:	1. OFIS reviews your request and checks that the denied service is covered. 2. If the grievance involves non-medical issues, it will be reviewed by the Commissioner of OFIS. 3. If the grievance involves medical issues, the request is assigned to an Independent Review Organization (IRO). 4. The Independent Review Organization reviews medical information and the denial and makes a recommendation within 14 calendar days. 5. OFIS reviews the recommendation of the Independent Review Organization.

When you will get a decision:	The review process takes approximately 26 days to complete: 1. OFIS will review your request within 5 business days. 2. The IRO has 14 calendar days to evaluate your case and make a recommendation. 3. In most cases, OFIS will contact you regarding the final decision within 7 business days of receiving the IRO recommendation.
In urgent situations:	If the denial seriously jeopardizes your life, health, or ability to regain maximum function, you may file for an expedited external review at the same time an expedited request is made to the health plan. OFIS will issue a decision within 72 hours. The urgency of the condition must be substantiated in writing by a licensed physician.

How to Get More Information:

Michigan Office of Financial and Insurance Services (OFIS), 877-999-6442
www.michigan.gov/ofis

Information updated as of 2-4-2005

Minnesota

General Information and Internal Plan Review:

For complaints that do not involve medical determinations, the internal complaint process for Minnesota health plans can take 30 days. If the complaint is not resolved in your favor, you can then appeal to the health plan, with a response in 30 to 45 days. If your complaint involves a medical determination, it will be handled by the 30-45 day appeal process. If an appeal is not resolved in your favor, you may apply for the external review process.

For appeals concerning disputes with health insurers such as Blue Cross/Blue Shield plans and indemnity plans, the case must be filed with the Minnesota Department of Commerce. Disputes with HMOs involving in-network issues are handled by the Department of Health.

The External Review Process:

Whom to contact:	Minnesota Department of Commerce or Department of Health
Who can appeal:	You, your provider (with consent), or your authorized representative
What you can appeal:	Denials of coverage for services the health plan determines are not medically necessary or are experimental or investigational. You can also appeal grievances related to contract disputes or other services.
When you can appeal:	You must file after the dispute has been appealed through the one level of the health plan's internal process and you have received an adverse determination.
What to send:	1. A completed Request for External Review, which includes a medical records release. 2. $25 check. 3. Any supporting information for your case.
What you must pay:	$25 (may be waived in cases of hardship)
What will happen:	1. The Department of Commerce or the Department of Health will evaluate your case for eligibility. 2. Your case will be sent to an independent review organization a. If your case does not involve a medical determination, you may request mediation, which involves a hearing by telephone or in person. Both you and your health plan must agree to mediate the dispute for this option to be used. b. If no agreement is reached, your case will be returned to the review organization. 3. You, your provider, and your health plan will be notified within 3 days after the review organization receives the case.

	4. You, your provider and your health plan may submit pertinent information to the review organization within 10 days after notification. 5. The review organization will evaluate your case and make a decision.
When you will get a decision:	Within 40 days after the case is submitted to the independent review organization.
In urgent situations:	For medical determinations for services that have not been received or are ongoing, if your provider believes an expedited review is necessary, a decision will be made within 72 hours.

How to Get More Information:

Minnesota Department of Commerce, 651-296-2488
www.commerce.state.mn.us

Minnesota Department of Health, 800-657-3916
www.health.state.mn.us/divs/hpsc/mcs/external.htm

Information updated as of 2-8-2005

Mississippi

As of January 1, 2005, Mississippi did not have an external review program for denials of coverage for services that health plans consider either experimental or not medically necessary.

How to Get More Information:

Contact your health plan.

Missouri

General Information and Internal Plan Review:

Missouri specifies three levels of review for their grievance procedure. The first level is through the health carrier only, and the second level involves external peer review by the health carrier. If after completing the second level you receive an adverse determination and your disagreement is about an issue of medical care, you may appeal to the third level, which is independent review.

The Independent Review Process:

Whom to contact:	Missouri Department of Insurance (MDI), Division of Consumer Affairs
Who can appeal:	You or your health plan
What you can appeal:	Denials of coverage for services the health plan determines do not meet requirements for medical necessity, appropriateness, health care setting, or level of care or effectiveness.
When you can appeal:	You may file after denial for coverage has been appealed and at any time through all levels of the health plan's internal process.
What to send:	Written request
What you must pay:	No charge
What will happen:	1. MDI checks that your request is appropriate for independent review. 2. MDI requests you and your health plan to submit all relevant and pertinent information within 20 days (although you may take longer if necessary). 3. MDI sends the entire request to the independent review organization. 4. The review organization notifies the Director of MDI of its decision. 5. The Director decides whether to agree or disagree (either entirely or in part) with the review organization's decision and tells the health plan how to respond. The decision of the Director is binding on the health plan, unless appealed.
When you will get a decision:	The review organization will usually respond within 20 days after it receives all pertinent information.
In urgent situations:	No statutory procedures for an expedited review to the independent review organization. MDI can request the review organization to expedite as a courtesy.

How to Get More Information:

Missouri Department of Insurance, 800-726-7390
www.insurance.state.mo.us

Information updated as of 9-9-2004

Montana

General Information and Internal Plan Review:

Montana's statute permits any party whose appeal of an adverse determination is denied by the health carrier or managed care entity to seek independent review of that determination by a peer. Montana requires the individual to go through the health plan's internal review process before accessing the independent review process. Montana has few requirements for internal review processes, but health plans are required to notify you and your provider of an adverse determination within 10 calendar days from the date a decision is made regarding routine medical care, or within 48 hours (excluding Sundays and holidays) if the condition qualifies for expedited review.

If you receive an adverse determination, the health plan will send you instructions for the internal appeal or independent review.

The Independent Review Process:

Whom to contact:	Your health plan
Who can appeal:	You or your authorized representative
What you can appeal:	"Adverse determinations," which are decisions by your health plan that health care services are not appropriate and medically necessary.
When you can appeal:	If your health plan has an internal appeal process, you may request an independent review of the health plan's adverse determination within 60 days after the date the internal review decision is made. If the internal appeals process is not completed within 60 days of receipt of the request for appeal, the process is interrupted and the case is forwarded for independent review. If your health plan does not have an internal appeal process, you have 180 days following the date of its adverse decision to request an independent review. If delay threatens your life or seriously threatens your health, the internal appeal process may be bypassed.
What to send:	Your health plan will provide an explanation of your rights to appeal and instructions on how to initiate an appeal or independent review.
What you must pay:	No charge
What will happen:	You and your health plan may agree on a peer to conduct an independent review. If you are both unable to agree, your case will be forwarded to the independent review organization designated by the Department of Public Health and Human Services.

When you will get a decision:	30 days after the review organization receives the case file (unless the review organization requests an extension from the Department).
In urgent situations:	An expedited review will be decided within 72 hours from the date the request is received.

How to Get More Information:

Montana Department of Public Health and Human Services, Quality Assurance Division, 406-444-2676

Information updated as of 9-2-2004

Nebraska

As of January 1, 2005, Nebraska did not have an external review program for denials of coverage for services that health plans consider either experimental or not medically necessary.

How to Get More Information:

Contact your health plan.

Nevada

General Information and Internal Plan Review:

Nevada's external review law applies to managed care organizations (MCOs) – insurers or other organizations that provide or arrange for the provision of health care services through managed care. Managed care includes management of the services used by an insured with a serious disease, utilization review, or financial incentives for using health care services effectively.

The External Appeal Review Process:

Whom to contact:	Your health plan
Who can appeal:	You, your provider, or your authorized representative
What you can appeal:	Denials or limitations of coverage for services costing you at least $500 that the health plan determines are not medically necessary.
When you can appeal:	You may appeal 1. within 60 days after receiving a final adverse determination from your health plan, or 2. if the MCO has not made a decision about your requested service within the required time period for internal review. The MCO may also submit the dispute to review without requiring you to exhaust all levels of internal review.
What to send:	A written request for external review
What you must pay:	No charge
What will happen:	1. Within 5 days of receiving your request for appeal, the MCO will notify you (or your representative or physician), the agent who performed the utilization review, and the Office for Consumer Health Assistance. 2. The Office for Consumer Health Assistance will assign an external review organization (ERO) to your appeal. 3. After being notified about the ERO assignment, the MCO has 5 days to provide all documents about your appeal to the ERO. 4. After being notified about your appeal, the ERO has 5 days to review your request and materials and to request additional information from you, your physician, or the MCO. 5. Within 15 days of receiving the information it needs to review your appeal, the ERO will decide your appeal.

	6. The ERO will notify you, your physician, your authorized representative (if any), and the MCO of its decision.
When you will get a decision:	Most appeals are resolved within 60 days.
In urgent situations:	If your physician provides evidence that a delay in treatment will be an imminent or serious threat to your health, you may request an expedited review. In this situation, the MCO must deny or approve the expedited external review within 72 hours after receiving the documentation from your provider. The ERO must complete its review within 2 working days after receiving the assignment (unless you and the MCO agree to a longer period) and notify your and the MCO of its decision by telephone within 1 working day after completing the review. The ERO has 5 working days after completing its review to provide the written decision.

How to Get More Information:

Governor's Office for Consumer Health Assistance, 702-486-3587 or 1-888-333-1597
http://govcha.state.nv.us/

Information updated as of 6-20-2005

New Hampshire

General Information and Internal Plan Review:

New Hampshire health plans must have written procedures for disputes regarding adverse determinations that provide for a standard review, a second-level grievance review, and expedited grievance review procedures in situations where delay would jeopardize the patient's life, health, or ability to regain maximum function. If you have exhausted your health plan's internal appeal process, you may file for external appeal.

The External Appeal Process:

Whom to contact:	New Hampshire Insurance Department
Who can appeal:	You or anyone you have given consent to represent you including your health care provider.
What you can appeal:	Denials of coverage for services the health plan determines are not medically necessary or are experimental or investigational. The cost of the denied services is or is anticipated in a 12-month period to be equal to, or in excess of, $400.
When you can appeal:	You must file within 180 days of the date of the health carrier's second- level denial. Some exceptions allow you to file earlier, such as if the health plan agrees to file earlier or if the health plan does not meet time requirements for decisions.
What to send:	1. Competed external appeal request form 2. Copy of letter denying service at final level 3. Evidence of insurance (e.g., photocopy of insurance card) 4. Copy of certificate of coverage or policy benefit booklet 5. Any medical records or other information you want the reviewer to consider
What you must pay:	No charge

What will happen:	1. Preliminary review by the Insurance Department within 7 days of receipt to determine if the request is complete and eligible for review. 2. If the request is not complete, you have 10 days to supply the information needed. 3. If the request is complete, the Insurance Department selects an independent review organization and notifies you and the health plan. 4. After the appeal is accepted, the insurer must provide all relevant information to you and the review organization within 10 days. 5. You then have 10 more days to submit new or additional information. You may in some circumstances be permitted to discuss the case with the reviewer by telephone conference. 6. The record of the case will be closed and no new information may be provided after the second 10-day window.
When you will get a decision:	20 days after the record of the case is closed
In urgent situations:	Expedited review is available if delay would seriously jeopardize your life, health, or ability to regain maximum function and must be completed within 72 hours.

How to Get More Information:

New Hampshire Department of Insurance, 800-852-3416
www.state.nh.us/insurance/

Information updated as of 7-15-2004

New Jersey

General Information and Internal Plan Review:

New Jersey requires you to complete 2 levels of internal appeal with your health plan prior to appealing for external appeal. The informal internal appeal can be initiated by a phone call to the health plan, by writing a letter, or by having your doctor file an appeal. You are supposed to receive a response within 5 business days or within 72 hours for an emergency. If you are still denied or restricted coverage, you may file a formal internal appeal either verbally or in writing (your health plan will provide the information you need to make this appeal). You are supposed to receive a response within 20 business days or within 72 hours for urgent or emergency care.

The External Appeal Process:

Whom to contact:	New Jersey Department of Health and Senior Services, Office of Managed Care
Who can appeal:	You, your doctor, or your authorized representative
What you can appeal:	Denials, reduction, termination, or limitations of covered health care services.
When you can appeal:	After denial for coverage has been appealed through the health plan's internal appeal process or the plan has not responded within the required deadlines, you must file within 60 days after your formal internal appeal is denied.
What to send:	A complete external appeal form (provided by your health plan) which asks for the following information: 1. Name and address of the health plan 2. Brief description of the pertinent medical condition 3. Copies of the Informal and Formal Internal Appeal denials 4. Written medical records release 5. Copy of your summary of insurance coverage
What you must pay:	$25 (may be reduced to $2 in cases of financial hardship)
What will happen:	1. The Department will refer your appeal to an independent utilization review organization. 2. The review organization will evaluate your appeal to determine if it is acceptable. 3. If your appeal is accepted for further review, you will receive a decision within 30 business days after all information needed for review has been received.
When you will get a decision:	30 business days after all information needed for review has been received.

In urgent situations:	If your appeal involves care for an urgent or emergency case, you will receive a response within 48 hours.

How to Get More Information:

New Jersey Department of Health and Senior Services, Office of Managed Care, 888-393-1062 (in-state only) or 609-633-0660,
www.state.nj.us/health/hcsa/hmomenu.htm

Information updated as of 8-16-2004

New Mexico

General Information and Internal Plan Review:

New Mexico has two types of appeals processes – one for utilization issues (External Review), and a separate process for non-utilization issues.

For utilization issues, New Mexico provides for an internal review, which consists of two steps with your health plan, prior to initiating the external review process. The internal review must be complete in whole within 20 working days.

The External Review Process:

Whom to contact:	New Mexico Superintendent of Insurance, State Corporation Commission
Who can appeal:	You or your provider with written consent
What you can appeal:	Denials of coverage for services the health plan determines are not medically necessary or a coverage benefit.
When you can appeal:	You must file within 20 working days after receiving the written notice from the health plan's internal review. An expedited external review may be appealed concurrently with the internal appeal.
What to send:	Completed request form, including a medical records release.
What you must pay:	No charge
What will happen:	1. The Division of Insurance will complete the external review within 20 working days or 72 hours for expedited reviews. 2. If the case is not accepted for an external review hearing, the Superintendent will notify the enrollee. 3. If the case is accepted, the Superintendent schedules the external hearing immediately. 4. A panel of independent hearing officers will hear the case. The panel will consist of two physicians and one attorney. 5. The panel will make a recommendation to the enrollee, health plan, and Superintendent after the hearing. 6. The Superintendent will evaluate the panel's recommendation and make a decision based on the evidence and the panel's recommendation and issue an appropriate order. 7. The order is binding on the health plan and the grievant. 8. Both the grievant and the health plan may take the case to district court.

When you will get a decision:	20 days after receipt of the request for external review and all necessary documentation.
In urgent situations:	Within 72 hours for an emergency

How to Get More Information:

New Mexico Managed Health Care Hot Line, 877-673-1732 or 505-827-3928
http://www.nmprc.state.nm.us/insurance/managedhealthcare/mhcpxreview.htm

Information updated as of 2-4-2005

New York

General Information and Internal Plan Review:

In New York, health plans must respond to internal appeals according to a specified time frame. If the internal appeal time frame is not met, the service must be provided by the health plan and an external appeal will be unnecessary. (Health plans must determine expedited appeals within 2 business days and standard appeals within 60 days). If you are denied coverage for requested services, your health plan considers either (1) not medically necessary, or (2) experimental or investigational, you may apply for an external appeal.

The External Appeal Process:

Whom to contact:	New York State Insurance Department
Who can appeal:	You, or your authorized representative, including your provider
What you can appeal:	Denials of coverage for services the health plan determines are not medically necessary or are experimental or investigational.
When you can appeal:	You must request an external appeal within 45 days from receipt of the final adverse determination from the first level of internal appeal with your health plan, or within 45 days of receipt of a letter from your health plan agreeing to waive the internal appeal process.
What to send:	Completed application (a physician's statement is required for Experimental/Investigational appeals) and a copy of the adverse determination letter or a letter from the health plan waiving the appeal.
What you must pay:	Up to $50 (the fee is waived under certain conditions). The fee is returned to the patient if the health plan denial is ultimately overturned.
What will happen:	The Insurance Department will: 1. Review the appeal request within 5 business days. 2. Assign the request to an external review agent if the request is eligible and complete. The external review agent will: 1. Have a medical expert (or experts) review the appeal. 2. Determine the outcome.
When you will get a decision:	30 days (plus 5 business days if additional information is requested)
In urgent situations:	An expedited appeal will be reviewed by the Insurance Department within 24 hours and the outcome determined by the external review agent within 3 days.

How to Get More Information:

New York State Insurance Department Hotline, 800-400-8882
www.ins.state.ny.us

Information updated as of 9-23-2004

North Carolina

General Information and Internal Plan Review:

North Carolina requires health plans to have an internal appeal and grievance process for noncertification decisions. In general, a request for external review will not be considered until the insured has exhausted the insurer's internal appeal and grievance process. If you are denied coverage for requested services that your health plan considers not medically necessary, you may request an external review.

The External Review Process:

Whom to contact:	North Carolina Department of Insurance, Healthcare Review Program
Who can appeal:	You or your authorized representative
What you can appeal:	External review is available when your health plan denies coverage for services or requested services on the grounds that they are not medically necessary.
When you can appeal:	You can file a request for external review within 60 days of receiving notice of your health plan's final decision from the highest level of appeal offered, or for expedited external review, within 60 days of receiving either the initial denial or decision on appeal.
What to send:	1. Completed external review request form, unless expedited request (which can be made orally or in writing) 2. Copy of notice of final determination denying coverage from insurer 3. Signed medical authorization release form, and 4. Copy of your health insurance card.
What you must pay:	No charge

What will happen:	The Healthcare Review Program will: 1. Conduct a preliminary review of your request to determine eligibility for external review. Within 10 business days after requesting external review, you will receive notification whether the request is complete and whether it has been accepted for review. Your health plan and provider will be notified at the same time. 2. If accepted for review, your case will be assigned to an independent review organization (IRO). 3. For a standard review, you may provide written information to the IRO within 7 days after the date of notice of acceptance. That same information must be provided to your health plan by the same means as it was provided to the IRO. The Independent Review Organization will: 1. Have a medical expert(s) review the case. 2. Make a determination in writing in which you, your provider, and insurer are notified of the decision.
When you will get a decision:	External review is performed on either a standard or expedited timetable, depending on which is requested and on whether medical circumstances meet the criteria for expedited review. A decision is issued by the IRO within 45 days of the Healthcare Review Program receiving the request for standard reviews.
In urgent situations:	An expedited external review of a noncertification decision (denial) may be available only when having first completed your health plan's internal appeal process (even on an expedited basis) or receiving a standard external review through the Healthcare Review Program would put your life, health, or recovery in serious jeopardy. A decision is issued by the IRO within 4 days of the Healthcare Review Program receiving the request.

How to Get More Information:

North Carolina Department of Insurance Healthcare Review Program, in-state toll free, 877-885-0231; Local, 919-715-1163
www.ncdoi.com

Information updated as of 8-30-2004

North Dakota

As of January 1, 2005, North Dakota did not have an external review program for denials of coverage for services that health plans consider either experimental or not medically necessary.

How to Get More Information:

Contact your health plan.

Ohio

General Information and Internal Plan Review:

Ohio requires HMOs to have internal procedures to handle disagreements regarding coverage for health services. If payment is denied, your provider may first request a reconsideration (with your consent). If you receive an adverse determination, you may then appeal through your health plan's internal procedures, and can expect a decision within 60 days. If the seriousness of your condition requires an expedited review, you will receive a decision within 7 days after your request is received.

If after appeal you still are denied payment for health services, you may request an external review. If your health plan does not complete its internal review within the required time frame, you may also request an external review. If your dispute concerns whether or not the service is covered under the contract, your case will be handled by the Superintendent of Insurance. If your dispute concerns medical issues, it will be sent to an external review organization.

Ohio's external review process applies to both HMOs and traditional insurance. Some traditional insurance plans have an internal review process that must be completed prior to applying for external review.

The External Review Process:

Whom to contact:	Your health plan
Who can appeal:	You, your provider (with consent), or your authorized representative
What you can appeal:	Denials, reductions, or terminations of coverage for services the health plan determines are (a) not medically necessary, (b) experimental or investigational and the enrollee has a terminal condition, or (c) questions of contract coverage (these are reviewed by the Superintendent of Insurance.) Unless your case qualifies for expedited review, your cost for the denied services must exceed $500. Questions of contract coverage and experimental/investigational reviews are not subject to the $500 certification.
When you can appeal:	After denial for coverage has been appealed through all levels of the health plan's internal process, within 60 days from receipt of the final adverse determination.
What to send:	1. A written request for standard reviews, or a phone call or fax followed up by written confirmation for expedited reviews. 2. If review is based on medical necessity, you must submit a certification from your provider that the cost to you for these services will exceed $500 (if applicable).
What you must pay:	No charge

What will happen:	For appeal of denial based on medical necessity or because the service is considered experimental or investigational and the enrollee has a terminal illness, you need to contact your health plan, who will then contact the Superintendent. 1. The Superintendent will randomly assign two independent review organizations to your case. 2. Your health plan will choose one of the independent review organizations. 3. The review organization will evaluate the information submitted and make a decision based on safety, efficacy, appropriateness, and cost effectiveness. For appeal of denial based on question of contract coverage, you need to contact the Superintendent. 1. The Superintendent will determine if your service is covered and notify your health plan. If the case involves medical issues that would cost you $500 or more, the Superintendent will notify your health plan to either cover the service or provide an external review. If the services would cost less than $500, the case does not qualify for external review and is outside the Department's jurisdiction.
When you will get a decision:	The Independent Review Organization has 30 days to complete the review for a standard review and 7 days for an expedited review. There is no time frame in which the Superintendent must complete the review.
In urgent situations:	Expedited review is available if delay will place your health in serious jeopardy, seriously impair your body function, or cause serious dysfunction of any body part or organ. For expedited review, your provider must explain why your medical condition is eligible. You will receive a decision within 7 days of filing for review.

How to Get More Information:

Ohio Department of Insurance Consumer Hotline, 800-686-1526
www.ohioinsurance.gov

Information updated as of 9-13-2004

Oklahoma

General Information and Internal Plan Review:

Oklahoma health plans are required to establish internal review procedures that are approved by either the Department of Insurance or the Board of Health (depending which agency regulates the health plan). If you have exhausted the internal review process, then you may request external review.

The External Review Process:

Whom to contact:	Your health plan
Who can appeal:	You or your authorized representative
What you can appeal:	Denials of coverage for services costing more than $1,000 that the health plan determines are not medically necessary, medically appropriate, or medically effective.
When you can appeal:	After denial for coverage has been appealed through all levels of the health plan's internal process, you must file within 30 days from receipt of the final adverse decision.
What to send:	A written request
What you must pay:	$50 (refunded if the external reviewer decides in your favor).
What will happen:	1. Your health plan will select an independent review organization. 2. The Department of Health will tell you which review organization was selected. 3. If you have reason to object to the selected reviewer, you may notify the Department within 3 days and the Department may allow you to select a different reviewer. 4. Within 5 days of final reviewer selection, you must provide: a. A written request for external review including the reasons why you are requesting the review, b. A copy of the decision to deny coverage from your health plan, c. A medical records release. 5. After receiving your information, the review organization will conduct a preliminary review to determine if your case is eligible for external review. 6. If your case is accepted for external review, your health plan will provide documentation within 5 business days of notification that the case has been accepted.

	7. Within 5 days of receiving the health plan documentation, the review organization will request any additional information it needs from you. You will have 5 business days to provide the information or explain why it can't be provided. 8. The review organization will decide your case.
When you will get a decision:	Within 30 days after acceptance of the request for external review and receipt of all documentation.
In urgent situations:	In an emergency that will jeopardize your life or health, an expedited review is available and you will receive a decision within 72 hours.

How to Get More Information:

Oklahoma State Department of Health, Managed Care Systems, 405-271-6868
www.health.state.ok.us

Information updated as of 2-17-2005

Oregon

General Information and Internal Plan Review:

Oregon law requires you to complete up to 3 levels of your health plan's internal grievance procedure before applying for external review, unless your health plan agrees to waive this requirement. Although you apply through your health plan, the Oregon Insurance Division selects the Independent Review Organization (IRO).

In addition to appeals based on disagreements about medical necessity and whether a procedure is experimental or investigational, Oregon allows appeals regarding "continuity of care." Oregon's continuity of care rules require managed care plans to continue to provide coverage with a particular provider for a limited period of time if that provider leaves an enrollee's health maintenance organization (HMO) network while the insured is undergoing an active course of treatment which the provider and patient consider medically necessary.

The External Review Process:

Whom to contact:	Contact your health plan
Who can appeal:	Anyone can request external review who is covered by a health benefit plan other than Medicare, the Oregon Health Plan, and employer self-insured plans.
What you can appeal:	You can appeal denials of coverage for services that the health plan considers either experimental or investigational, or not medically necessary. You can also appeal denial of continuity of care with a provider who leaves your HMO.
When you can appeal:	After denial for coverage has been appealed through up to 3 levels of the health plan's internal process; you must request external review within 180 days from receipt of the final adverse decision.
What to send:	A written request for external review. If the patient is in serious danger of life-threatening injury or impairment pending a 30-day review process, the request should state "expedited review" and include testimony from a health care professional as to the potential danger.
What you must pay:	No charge; all costs are paid by the insurer.

What will happen:	Your health plan will forward your request for external review to the State of Oregon's Insurance Division within 2 days. The Consumer Advocate Liaison will assign your case to an IRO and tell you which IRO will review your case. If there is a conflict of interest, you may challenge the choice of IRO within 2 days of receiving the notice by contacting the Consumer Advocate Liaison. The IRO will: 1. Determine if your request qualifies for external review. 2. Accept additional information from you, your provider, or your health plan within 7 days. 3. Review your case and notify you and your health plan of its decision.
When you will get a decision:	For a standard review, you will receive a decision from the IRO within 30 days of your request for independent review.
In urgent situations:	You, your provider, or your health plan may submit additional information within 24 hours of an expedited request. An expedited review produces a decision within 3 days of your request.

How to Get More Information:

Oregon Department of Consumer & Business Services, Insurance Division, 503-947-7269
www.oregoninsurance.org/docs/consumer/exreview/external_review_info.htm

Information updated as of 8-31-2004

Pennsylvania

General Information and Internal Plan Review:

Pennsylvania distinguishes between grievances and complaints, and has separate procedures for each type of problem. A grievance is any request to have a review of a denial of a covered health service on the basis of medical necessity or appropriateness. A complaint relates to most other problems regarding health plan operations, quality of care or service, contract exclusions, or covered benefits.

Problems are initially filed with the health plan, which usually decides if the issue is a grievance or a complaint. If grievances are not satisfactorily resolved in their two-step process, they can be appealed for review by an independent utilization review organization. If complaints are not satisfactorily resolved in a two-step process with the plan, they may be appealed to either the Department of Health or the Insurance Department.

The External Grievance Appeal Process:

Whom to contact:	Your health plan
Who can appeal:	You or your provider (with written permission), or your authorized representative If your provider files the grievance, he or she will be responsible for the cost of the review if the denial is upheld by the independent utilization review organization.
What you can appeal:	Denials of coverage for services the health plan determines are not medically necessary or appropriate.
When you can appeal:	After denial for coverage has been appealed through the second level of the health plan's internal process, you must appeal within 15 days from receipt of health plan's decision.
What to send:	1. Enrollee's name, address, and phone number 2. Name of health plan 3. Enrollee ID number 4. Copy of denial letter 5. Brief description of the problem 6. Any additional material that supports your position.
What you must pay:	Up to $25
What will happen:	1. The health plan will notify the state. 2. The state will assign your case to an independent utilization review organization. 3. The review organization will evaluate your case and provide written notice to you, the health plan, and the Department of Health.
When you will get a decision:	In about 60 days

In urgent situations:	If delay will jeopardize your life, health, or ability to regain maximum function, you should work with your plan to facilitate an expedited review, which will result in a 48-hour turn-around time. Expedited reviews are also processed at the state level within two working days.

How to Get More Information:

Complaints or Grievances: Bureau of Managed Care, 888-466-2787
Complaints: Pennsylvania Insurance Department, 877-881-6388
www.health.state.pa.us (follow link to “Provider,” and then to “Managed Care”)

Information updated as of 2-12-2005

Rhode Island

General Information and Internal Plan Review:

Rhode Island specifies that health plans provide two levels of internal appeal. If you receive an adverse determination after completing the second level of internal appeals, you may apply for external review.

The External Review Process:

Whom to contact:	The review agent that rendered the adverse decision
Who can appeal:	You, your provider, or your authorized representative
What you can appeal:	Adverse decisions, which are decisions by a review agent not to certify a health care service.
When you can appeal:	After denial for coverage has been appealed through the 2nd level of the health plan's internal process, you must file within 60 days from receipt of the 2nd level appeal denial.
What to send:	Notices of adverse decisions will contain instructions for how to initiate the next level of appeal.
What you must pay:	Half of the cost of the review. The cost depends on which external review agency is used. If the adverse decision is overturned, your payment will be refunded.
What will happen:	1. You will select the external review agency. 2. The review agent will provide information to the external appeals agency within 5 days of receiving the initial notification of appeal. 3. The external appeals agency will review the information and make a determination. The appeal will not be processed until the fee and all required documentation is received.
When you will get a decision:	Within 10 business days
In urgent situations:	In an emergency, an expedited appeal will be reviewed and decided by the external appeals agency within 2 days.

How to Get More Information:

Contact your health plan or utilization review agent for information concerning appeals
Rhode Island Department of Health, 401-222-6015

Information updated as of 2-4-2005

South Carolina

General Information and Internal Plan Review:

South Carolina requires you to complete your health plan's internal appeals process before asking for an external review, except in the following circumstances: 1) your treating physician has certified in writing that you have a serious medical condition, 2) the service is experimental or investigational and your treating physician has provided the required certifications, 3) the health plan has not issued a written decision within the time frames set forth in the plan's internal appeals process, or 4) the health plan agrees to waive the internal appeals process.

The External Review Process:

Whom to contact:	Your health plan.
Who can appeal:	You or your authorized representative
What you can appeal:	Denied health services that are not considered medically necessary, effective, appropriate, at the appropriate level of care, or provided in the appropriate setting. For conditions that are life threatening or seriously disabling, services considered experimental or investigational may be appealed. The amount payable for covered benefits must be at least $500.
When you can appeal:	For a standard review, you must apply within 60 days after receiving notice that your request for services has been denied. You must apply within 15 days for an expedited review.
What to send:	Request an external review in writing.
What you must pay:	No charge

What will happen:	Within 5 business days of receiving your request for external review, your health plan will either: 1. Assign your case to an independent review organization and send documentation to the review organization, or 2. Notify you in writing why your request does not meet the requirements for external review. If your health plan does not send the documentation, the review organization may terminate the review and reverse the adverse determination or final adverse termination. Within 5 business days of receiving the request for external review, the review organization will evaluate whether or not the necessary information has been received and notify you if additional information is needed. You must also submit additional information and documentation to support your case within 7 business days after receiving this notification. In general, the review organization will evaluate the documentation and make a decision. If your appeal concerns an experimental or investigational treatment, the review organization will select a review panel and the reviewers will submit written opinions. The review organization will then make a decision to uphold or reverse your health plan's determination. Decisions regarding denials of experimental or investigational treatments must be based on the recommendation made by the majority of the panelists.
When you will get a decision:	Within 45 days after the review organization receives the request from your health plan.
In urgent situations:	An expedited review is available if the patient has a serious medical condition or is requesting continued care after receiving emergency treatment. You must apply for expedited review within 15 days of receiving notice that your request for services has been denied. A decision will be made no more than 3 business days after the request was received by the health plan.

How to Get More Information:

Department of Insurance Consumer Services Division, 800-768-3467 or 803-737-6180
https://www.doi.state.sc.us/Eng/Public/Consumer/PatientsGuidetoER.pdf

Information updated as of 8-30-2004

South Dakota

As of January 1, 2005, South Dakota did not have an external review program for denials of coverage for services that health plans consider either experimental or not medically necessary.

How to Get More Information:

Contact your health plan.

Tennessee

General Information and Internal Plan Review:

For HMOs, Tennessee requires consumers to use their health plan's internal grievance process prior to asking the Commissioner of the Insurance Division for a review. Health plans must provide not only an initial review, but also a reconsideration of the review if you request one.

If you are unsatisfied with the results of your review you may either ask your health plan for an independent review, which can cost $50, or can ask the Insurance Division to review the decision, which is available at no charge. The two processes use different rules and timelines; independent review through the health plan is described below. HMO grievances filed with the Insurance Division are reviewed by Division staff, which includes a physician.

The Independent Review Process:

Whom to contact:	Your health plan
Who can appeal:	You or your authorized representative
What you can appeal:	Denials of coverage for services the health plan determines are not medically necessary or are experimental. The cost of the proposed service to the health plan must be at least $500.
When you can appeal:	After completing the HMO internal grievance process, within 60 days of receiving final notification that coverage will be denied.
What to send:	A written letter including any pertinent documentation
What you must pay:	Up to $50
What will happen:	1. Your health plan has 5 days to provide all pertinent information to the independent review entity. 2. The independent review entity will request any additional information from you and your doctor within 5 days of receiving the information from the health plan. 3. The independent review entity will review your case and make a decision.
When you will get a decision:	Within 30 days of receiving the request for review. (The expert may request an extension of 5 additional days to consider additional information.)
In urgent situations:	For life-threatening conditions, a decision will be made within 5 days.

How to Get More Information:

Tennessee Department of Commerce and Insurance, 615-741-2825 or 800-861-1270

Information updated as of 2-7-2005

Texas

General Information and Internal Plan Review:

Texas requires health plans and Utilization Review Agents (URAs) for those plans to have an internal appeal procedure. If you have exhausted your plan or URA's internal appeal procedure and are still denied coverage for care because the plan or URA regards the care as not medically necessary or appropriate, then you may file for independent review by an Independent Review Organization (IRO). You cannot be required to exhaust your plan's internal appeal process if you have a life-threatening condition and can request the review immediately. If the IRO disagrees with the health plan or URA's denial, your health plan will be required to pay for the requested care.

You are not eligible for an independent review if the denial is not based on medical necessity (i.e., the contract does not cover the service or treatment requested or the treatment is experimental). You may, however, appeal to the health plan or you may file a complaint with the Department of Insurance. You also may not request eligible for an independent review if prospective or concurrent review was not performed by the health plan or its utilization review agent, you have already received the services and your health plan then determines that the treatment was not medically necessary or appropriate (retrospective review). However, you are entitled to appeal the denial of the claim to the health plan. In addition, not all health plans are required to participate in the IRO process (i.e., Medicare plans). You should call your health plan to determine whether the plan participates in the IRO process.

The Independent Review Process:

Whom to contact:	Your health plan or its utilization review agent
Who can appeal:	You, your provider, and your authorized representative (although only you or your legal guardian may sign a medical records release form). Your provider may appeal the denial without your consent if you are not reasonably available or competent to consent.
What you can appeal:	Prospective or concurrent denials of coverage for services that the health plan or its utilization review agent determines are not medically necessary or appropriate.
When you can appeal:	After denial for coverage has been appealed through the health plan's or its utilization review agent's internal process, or immediately to the IRO if you have a life-threatening condition. There is no time limit.
What to send:	A completed independent review request form (the health plan or its utilization review agent is required to provide you with this form at the time it denies services and again if your appeal is denied). Send to your health plan or its utilization review agent at the address or fax number listed at the bottom of the request form.
What you must pay:	No charge to you; the health plan or its utilization review agent must pay for the IRO review.

What will happen:	1. The health plan or its utilization review agent will immediately notify the Department of Insurance that you have requested an independent review. 2. The Department will randomly assign your case to an independent review organization within one business day of receiving a complete IRO request. 3. The Department will notify the health plan or its utilization review agent, the patient and the providers, involved about the assignment. 4. The health plan or its utilization review agent will send all pertinent information to the IRO by the 3rd day after receiving your review request. 5. The IRO will make a determination.
When you will get a decision:	Either 15 days after receiving necessary information or 20 ~~business~~ days after receiving your request for independent review.
In life-threatening situations:	Either 5 days after receiving necessary or 8 days after receiving your request for independent review.

How to Get More Information:

HMO/URA Division, (512) 322-4266
IRO Information Line, 888-834-2476, (322-3400 in Austin)
Consumer Help Line, 800-252-3439, (463-6515 in Austin)
www.tdi.state.tx.us

Information updated as of 8-2-2004

Utah

General Information and Internal Plan Review:

Utah requires health plans to follow the adverse benefit determination review requirements established by the U.S. Department of Labor in its Claim Procedure rules for employer-sponsored health plans.

The Independent Review Process:

Whom to contact:	Your insurance carrier
Who can appeal:	You or your authorized representative
What you can appeal:	Adverse benefit determinations of medical necessity.
When you can appeal:	You may appeal within 180 calendar days from the date of the final review decision of the internal review process.
What to send:	Independent reviews need to be requested in writing, while expedited reviews may be submitted orally or in writing. You will want to provide the insurer with as much information as possible so the independent review organization can conduct a complete and fair review.
What you must pay:	No charge
What will happen:	Your request for a review will be handled as an independent review, unless there is an urgent medical situation and then it will be handled as an expedited review. Independent reviews: 1. You must exhaust the insurers internal review process unless you and the insurer mutually agree to waive the internal process. 2. You must send your insurer a written request for an independent review within 180 days from the date of the final internal review decision. 3. Your insurer will select an Independent Review Organization to conduct the review. 4. Your insurer will send you notification of the Independent Review Organization's decision. This notification will include the reasons for the decision, reference to the specific plan provision on which the decision is based. 5. The independent review decision can be binding and final.

	Expedited reviews: 1. You may submit a request for an expedited review either orally or in writing. If your insurer receives an oral request for an expedited review, the insurer will send you a written confirmation of the request within 24 hours. 2. Your insurer will select an Independent Review Organization to conduct the review. 3. Your insurer will send you notification of the Independent Review Organization's decision. This notification will include the reasons for the decision, reference to the specific plan provision on which the decision is based. 4. The expedited review decision is binding and final.
When you will get a decision:	Within 30 days for an Independent Review of a pre-service claim, and within 60 days for a post-service claim.
In urgent situations:	The insurer will notify you as soon as possible, but no later than 72 hours after receiving your request for an expedited review.

How to Get More Information:

Utah State Insurance Department, 801-538-3805 (Salt Lake City), 800-439-3805 (other Utah areas), 801-538-3826 (TDD)
www.insurance.utah.gov

Information updated as of 9-29-2004

Vermont

General Information and Internal Plan Review:

Vermont health plans must follow state rules regarding internal appeals. Generally, if you have exhausted the internal appeals for your health plan, you are eligible to request an external appeal (although there are different rules for mental health and substance abuse services).

External appeals for mental health or substance abuse services are decided by the Independent Panel of Mental Health Providers. External appeals for other services are decided by independent review organizations. You can initiate an external appeal for any type of health care service by calling the Division of Health Care Administration of the Department of Banking, Insurance, Securities and Health Care Administration at 800-631-7788 or 802-828-2900.

The Appeal Process (not for mental health or substance abuse):

Whom to contact:	The Division of Health Care Administration of the Department of Banking, Insurance, Securities and Health Care Administration
Who can appeal:	You or a representative of your choice
What you can appeal:	Denials, reductions, or terminations of coverage for claims of at least $100: 1. For covered services the health plan determines are not medically necessary. 2. Limitations on selection of providers that are inconsistent with laws, regulations, or plan limits. 3. For services determined to be experimental or investigational, or an off-label use of a drug. 4. Medically-based determination of a pre-existing condition.
When you can appeal:	After denial for coverage has been appealed through all levels of the health plan's internal process, you must file within 90 days from receipt of the written adverse determination.
What to send:	1. A completed request for appeal form. 2. The filing fee (check or money order) or request for waiver or reduction of fee.
What you must pay:	$25 (the fee is waived under certain conditions).

What will happen:	1. The Division will evaluate the request and determine whether or not it qualifies for external review within 5 days. 2. The Division will contact you regarding whether or not your request is accepted for review. 3. If your request is accepted for review, the Division assigns your case on a rotating basis to an independent review organization. 4. The Division will ask you and your health plan to send it the pertinent documentation within 10 days. Your health plan may request an extension of up to 10 days for good cause. You may request an extension for any reason. 5. The Division will send you and your health plan the documentation provided by the other party. You and your health plan have 3 days from receiving the information to send a response to the Division. 6. After the documentation and responses have been received, the Division will send all of the documentation to the independent review organization assigned to your case. 7. The review organization will evaluate the information. You may have a telephone conference with the review organization and the health plan if you requested this on your application.
When you will get a decision:	30 days from the review organization's receipt of the appeal. The review organization may request an extension for circumstances beyond its control, including receipt of additional information after it has received the appeal.
In urgent situations:	There is an expedited process in emergency or urgent care situations. An expedited appeal will be immediately considered, documentation must be submitted to the Division, and a review organization assigned within 48 hours of acceptance. The review organization will respond within 5 days, unless it determines that your case is not urgent.

How to Get More Information:

Division of Health Care Administration, 800-631-7788 (in Vermont), 802-828-2900
www.bishca.state.vt.us/hcadiv/consumintro.html
The Vermont Office of Health Care Ombudsman (800-917-7787 or 802-863-2316) can assist consumers with appeals and other health insurance issues.

Information updated as of 9-13-2004

Virginia

General Information and Internal Plan Review:

Virginia health plans must receive approval of their internal appeal processes from the both the Virginia Bureau of Insurance and the Department of Health.

The Virginia Bureau of Insurance has an Office of the Managed Care Ombudsman that is available to help you prepare an internal appeal.

The External Appeal Process:

Whom to contact:	Virginia Bureau of Insurance (BOI)
Who can appeal:	You, your provider (with your consent), or your authorized representative
What you can appeal:	Denials of coverage for services the health plan determines are not medically necessary or involve experimental or investigative procedures. The cost of the denied services must exceed $300.
When you can appeal:	After denial for coverage has been appealed through all levels of the health plan's internal process, you must file within 30 days of the final decision to deny coverage.
What to send:	A completed appeal form (you can call the ombudsman for help)
What you must pay:	$50 (the fee may be waived for financial hardship and is refunded if you are not eligible)
What will happen:	1. The BOI will review your appeal to verify eligibility. 2. The BOI will select an independent healthcare review organization. 3. You, your physician, and the health plan will be asked to provide pertinent information within 20 working days. 4. The review organization will recommend a decision. 5. The Commissioner of Insurance will review the recommendation to assure that it is not arbitrary or capricious.
When you will get a decision:	30 working days after the review organization receives all pertinent information.
In urgent situations:	An expedited appeal is available in an emergency or if required by an emergency medical condition. The BOI will decide if your situation warrants an expedited appeal, and, if so, the review organization will decide your case within 5 working days after the review organization receives all pertinent information.

How to Get More Information:

State Corporation Commission, Bureau of Insurance, 800-552-7945 (in Virginia only), 804-371-9206 TDD
www.state.va.us/scc/division/boi
Office of the Managed Care Ombudsman, 877-310-6560, 804-371-9032 (Richmond)

Information updated as of 9-16-2004

Washington

General Information and Internal Plan Review:

Washington requires each health plan to have an internal grievance process of appeals for either complaints or limitations in services. These appeals must be resolved within 30 days (or within 72 hours if delay would seriously jeopardize your life, health, or ability to regain maximum function). After exhausting your health plan's internal appeals you may request an independent review.

While disputing limitations in services, you may request that your health plan continue to provide service. If the independent review is ultimately decided in favor of your health plan, you may be responsible for the cost of this continued service.

The Independent Review Process:

Whom to contact:	Your health plan
Who can appeal:	You or your authorized representative
What you can appeal:	Denials, modifications, reductions, or terminations of either coverage or payment for health care services.
When you can appeal:	After you have exhausted your health plan's internal grievance procedure and have received an unfavorable decision, or if your health plan has exceeded the timelines for the internal procedure without good cause.
What to send:	Oral or written request. Each carrier must provide a clear explanation of the process upon request, upon enrollment to new enrollees, and annually to enrollees.
What you must pay:	No charge
What will happen:	1. Your health plan will select a certified independent review organization from the Insurance Commissioner's designated rotational registry. 2. Your health plan will provide the pertinent documentation to the review organization within 3 business days of receiving your request for review. 3. The review organization will make a decision.
When you will get a decision:	Either 15 days after the review organization receives all necessary information or 20 days after the request for review, whichever is earlier. (In exceptional circumstances, the review organization may be allowed 25 days after the request for review.)

In urgent situations:	If delay would seriously jeopardize your health or ability to regain maximum function, you should get a decision within either 72 hours after the review organization receives all necessary information or 8 days after the request for review, whichever is earlier.

How to Get More Information:

Office of the Insurance Commissioner Consumer Hotline, 800-562-6900
www.insurance.wa.gov

Information updated as of 2-14-2005

West Virginia

General Information and Internal Plan Review:

West Virginia provides that a managed care plan may apply for exemption from the state external review process if it already has an external review plan in place and the external review plan has been reviewed during the certification process for the health maintenance organization. The details of applying for external review with those individual plans are governed by the HMO documents, but they approximate the statutory requirements discussed here.

The External Review Process:

Whom to contact:	West Virginia Insurance Commissioner and the managed care plan
Who can appeal:	You
What you can appeal	Managed care plan's decision to deny, modify, reduce, or terminate coverage or payment for a health care service. External reviews relate only to questions of whether a health care service is medically necessary or whether a health care service is experimental, and the decision must involve services totaling $1,000 or more.
When you can appeal:	After exhausting your managed care plan's internal grievance procedure, within 60 days of receiving an unfavorable decision by the managed care plan, or 60 days after the managed care plan has exceeded the time periods for grievances without reaching a decision.
What to send:	Request for external review form and release of medical records
What you must pay:	No charge
What will happen:	The Insurance Commissioner will notify the enrollee and the health maintenance organization of the internal review procedure within 7 days, after which the health maintenance organization and the enrollee must forward to the assigned external review organization all relevant documents and information in their possession.
When you will get a decision:	Decisions are due within 45 calendar days from the date of the request for external review. In expedited procedures, the decision must be made within 7 calendar days after the request is received by the Insurance Commissioner.

In urgent situations:	For decisions where delay would place the health of the enrollee or the health of the enrollee's unborn child in serious jeopardy, an expedited review process is provided. For an expedited procedure, the Insurance Commissioner issues a notice within 2 business days and the health maintenance organization and the enrollee must respond with information within 2 business days. An expedited review produces a decision within 7 calendar days of the date the request for review is made.

How to Get More Information:

Contact your health plan or Office of the Insurance Commissioner, Consumer Service Division, 888-879-9842, 800-435-7381 (TTY)
www.wvinsurance.gov/consumer/hmo_grev.htm

Information updated as of 2-28-2005

Wisconsin

General Information and Internal Plan Review:

Wisconsin law already requires health plans to establish internal grievance procedures that must be approved by the Commissioner of Insurance.

For independent review, Wisconsin allows you to select the organization that will review your case from a list of certified review organizations.

The Independent Review Process:

Whom to contact:	Your health plan
Who can appeal:	You or your authorized representative
What you can appeal:	Denials of coverage for services the health plan determines are not medically necessary, appropriate, or effective, services that are not provided in the required health care setting, or services that are experimental. The amount in dispute must exceed $256.
When you can appeal:	After denial for coverage has been appealed through the health plan's internal process, you must file within 4 months from receipt of the final adverse determination or experimental treatment determination.
What to send:	1. Written request 2. The name of the review organization you want to review your case.
What you must pay:	$25 (if the review organization rules in your favor, even in part, your payment will be refunded)
What will happen:	1. Your health plan must submit all pertinent documents to the independent review organization within 5 business days of receiving your request. 2. The independent review organization will request any additional information it needs within 5 business days of receiving the initial documentation from your health plan. 3. Your health plan will send any additional information within 5 days of receiving the request for additional information. 4. You or your health plan may also submit additional medical or scientific evidence to each other and the review organization.
When you will get a decision:	Within 30 business days after the last of the data request time limits

In urgent situations:	If the independent review organization determines that the required time limits would jeopardize your life, health, or ability to regain maximum function, an expedited review is available. Information will be submitted by your health plan within 1 day, additional information will be requested within 2 days and then submitted within 2 days, and the review organization will make a decision within 72 hours after the last of the data request time limits.

How to Get More Information:

Office of the Commissioner of Insurance, 800-236-8517 (in Wisconsin)
www.oci.wi.gov

Information updated as of 2-4-2005

Wyoming

As of January 1, 2005, Wyoming did not have an external review program for denials of coverage for services that health plans consider either experimental or not medically necessary.

How to Get More Information:

Contact your health plan.

Consumers Union
101 Truman Ave
Yonkers, NY 10703
Phone: 914-378-2000

www.consumersunion.org

The Henry J. Kaiser Family Foundation
2400 Sand Hill Road
Menlo Park, CA 94025
Phone: 650-854-9400 Fax: 650-854-4800

Washington Office:
1330 G Street, NW
Washington, DC 20005
Phone: 202-347-5270 Fax: 202-347-5274

www.kff.org

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