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CONSUMER GUIDE TO THE HEALTH CARE APPEALS PROCESS IN ARIZONA

This document is intended to provide a brief description of the Health Care Appeals process.

A more detailed explanation is provided in the Health Care Appeals Information Packet available from your health insurance company. If you file a complaint with the Arizona Department of Insurance (Department) related to a denial of claims or a request for service that is subject to the appeals process, the Department must require you to first pursue the appeals process with your insurance company. The Department cannot address your complaint during the appeals process, unless your complaint is about an issue other than the denial of your claim or request for service.

What is the Health Care Appeals process?

Arizona law requires health insurance, dental and vision plans to provide their members with a way to appeal denied claims or services. A "denied claim" is when you have already received care, and the insurance company has denied payment for that care. A "denied service" is when the plan does not authorize a medical or health-related service that is covered by the plan, or the plan does not pre-authorize any treatment or procedure that you or your doctor believe is medically necessary and covered by your policy. When your health insurance company denies a claim or service, it must advise you of your right to appeal the denial.

The appeals process generally consists of the following levels of review:

For urgently needed services not yet provided:

- Expedited Medical Review
- Expedited Appeal
- Expedited External Independent Review

For standard services or denied claims:

- Informal Reconsideration
- Formal Appeal
- External, Independent Review

Urgently needed services not yet provided

Expedited Medical Review

An Expedited Medical Review is the first step for urgently needed services that you are waiting to receive, but your insurance company has said to you or your treating provider or doctor that it will not pay for the services. The Expedited Medical Review starts when your treating provider or doctor sends a certified notice to your insurance company that delaying the requested medical or health-related service could cause a significant negative change in your medical condition. The insurance company has one business day after receiving your doctor's certified notice and the appeal to notify you and your doctor in writing. If your insurance company still believes that it should not cover the requested service after the Expedited Medical Review is completed, it must inform you by phone and in writing of your right to then request an Expedited Appeal, the next step in the appeal process.

Expedited Appeal

If the insurance company denies the requested medical or health-related service following the Expedited Medical Review, and you still wish to appeal the insurance company's decision, your treating provider or doctor must immediately submit a written appeal to the insurance company and provide any additional reasons and/or documents supporting the request for the medical or health-related service. The insurance company has three business days to make a decision after receiving the additional information from your treating provider or doctor. If the insurance company still believes that it should not cover the requested medical or health-related service, the insurance company must inform you and your treating provider or doctor by phone and in writing of the denial and of your right to immediately proceed to an Expedited External Independent Review, the next step in the appeal process. The next step requires action within five business days.

Expedited External Independent Review

You must act within five business days after you are notified that your Expedited Appeal for medical or health-related services was denied to request an Expedited External Independent Review. Your insurance company must act promptly. Within one business day of receiving your notice asking for an Expedited External Independent Review, the

insurance company will send all documentation used to make its earlier decisions to the Department.

If the request for Expedited External Independent Review is for a medical necessity, the Department forwards the submitted materials to an independent review organization selected by the Department. The review organization is under contract with the State of Arizona to provide services to the Department, and is not related to your insurance company. The review organization assigns your matter to a reviewer. The reviewer must be a doctor who typically manages the medical condition for which the treatment is being denied, and may not have any conflict of interest that will prevent him or her from making a fair and impartial decision. The review organization has 72 hours to notify the Department of its decision. The Department then has one business day from when it receives the reviewer's decision to notify you, your treating provider or doctor and your insurance company of the decision.

If the request for Expedited External Independent Review is for a question of insurance coverage for a medical or health-related treatment, the Department has two business days to review the information provided by the insurance company and determine if the denied service is covered under the insurance policy. The Department will notify you, your treating provider or doctor and your insurance company of its decision.

Standard services or denied claims

Informal Reconsideration

Informal Reconsideration is the first step in the appeals process for denied claims and services when you do not qualify for Expedited Medical Review. Some insurance companies may require that you go straight to a Formal Appeal and you should review your insurance policy to determine if your company allows only a formal appeal. You may request an Informal Reconsideration by calling in or sending your request in writing to your insurance company. You have up to two years after your insurance company denies your claim or request for a covered service to request an Informal Reconsideration. The insurance company has 30 days to make a decision and notify you and your doctor or treating provider or doctor of that decision. If the insurance company still denies your request for service or denies your claim after the Informal Reconsideration is completed, you may then request a Formal Appeal.

Formal Appeal

If your insurance company denies your request for a covered service after an Informal Reconsideration, or requires you to use the Formal Appeal process you may request a Formal Appeal.

If your insurance company requires you to use the Informal Reconsideration process before using the Formal Appeal process, you have 60 days following the completion of the Informal Reconsideration process of a denied service to request a Formal Appeal. If your insurance company requires appeals of denied claims to begin at the Formal Appeal level, you have up to two years after the last denial occurred to request a formal appeal of your denied claim.

For denied services, when your insurance company has received your notice of Formal Appeal, it has 30 days to make its decision and to notify you. For denied claims, the insurance company has 60 days to make its decision and to notify you of the decision. If the insurance company still denies your request for service or a claim for a service, you can then request an External, Independent Review.

External, Independent Review

The last step after a Formal Appeal for denied services or denied claims by your insurance company is the External Independent Review. You have four months after your insurance company notifies you that your Formal Appeal was denied to request an External, Independent Review. When you submit your request for the External, Independent Review, your insurance company has five business days to respond and send all documentation used to make its earlier decision to the Department.

For medical necessity cases, when the Department receives the documentation from the insurance company, it has five business days to forward the materials to an independent review organization selected by the Department. The review organization is under contract with the State of Arizona to provide services to the Department, and is not related to your insurance company. The review organization assigns your matter to a reviewer. The reviewer must be a doctor who typically manages the medical condition for which the treatment is being denied, and may not have any conflict of interest that will prevent him or her from making a fair and impartial decision. The reviewer has 21 days to notify the Department of its decision. The Department then has five business days from when it receives the reviewer's decision to notify you, your treating provider or doctor and your insurance company of the decision.

For cases involving an insurance company's denial of coverage for a medical service or claim, the Department has 15 business days to review the information provided and determine if the denied service or claim is covered under the policy. The Department will notify you, your doctor treating provider or doctor and your insurance company of its decision. If the Department is unable to determine if the claim is covered under the policy, it may then send the case to an independent review organization and this organization assigns a physician to review the record and determine if the service or claim is covered under the insurance policy. The reviewer must be a doctor who typically manages the medical condition for which the treatment is being denied, and may not have any conflict

of interest that will prevent him or her from making a fair and impartial decision. The medical reviewer has 21 days to send a decision to the Department and you would be notified of the decision within five business days.

The reviewer's decision is legally binding upon the insurance company and you, even if you or the insurance company disagrees with the decision. Either you or the insurance company may petition this decision to a state court following the completion of the external, independent review that was decided by a medical reviewer.

When the Department determines whether a claim is covered under a health insurance policy, this decision may be reviewed by the Arizona Office of Administrative Appeals. If you or the insurance company disagree with the Department's decision regarding coverage issues, either party may request a hearing. Hearings must be requested within 30 days of receiving the decision from the Department.

When you receive the Department's decision, it includes instructions for requesting a hearing. Please keep in mind, however, that the independent review organization, the Department of Insurance and the Office of Administrative Hearings cannot require an insurance company to pay a claim or provide a service that is excluded from coverage by your policy.

What kinds of matters will not qualify for the Heath Care Appeals process?

Individuals with health care coverage through a Medicare HMO, Medicare supplement plan, long-term care plan, a multi-employer plan under ERISA, a federal employee plan, or any self-funded or self-insured plan are not eligible to participate in the appeals process described above. Workers' compensation claims and disputes are also not eligible for this appeals process. These other plans normally have an appeals process of some kind that you may use, but the appeals process in those other plans are spelled out in the plan documents.

Individuals with complaints concerning how you were treated by a health care provider, health care benefit reductions due to usual and customary charge limitations, deductibles, and coordination of benefits issues are not eligible for the health care appeals process described above.

Helpful hints

Include Documents: If you decide to file a health care appeal with your insurance company, make sure to include as much supporting documentation as possible that shows why you believe the denied service or claim should be covered. When filing an Expedited Medical Review, the doctor's written certification that delaying treatment will negatively impact your medical condition must be included.

Understand What Can Be Appealed: Remember that you cannot request an External, Independent Review before you have completed any applicable Formal Appeal, Informal Reconsideration or Expedited Medical Review. Please also keep in mind that this is only a brief description of the way the appeals process will generally work at most insurance companies.

Every Health Care Company Has Its Own Process: There can be some variation from company to company. Please refer to the Health Care Appeals Information Packet available from your insurance company for more specific details regarding how your insurance company handles appeals. If you are not able to locate this information, please contact your insurance company or the Department of Insurance at https://insurance.az.gov/consumers/help-problem.

Persons with disabilities may request materials be presented in an alternative format by contacting the ADA Coordinator at (602) 364-3100. Requests should be made as early as possible to allow time to procure the materials in an alternative format.