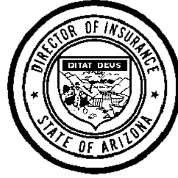
PRESS RELEASE



JANE DEE HULL
GOVERNOR

JOHN A. GREENE
DIRECTOR

ARIZONA DEPARTMENT OF INSURANCE

2910 North 44th Street, Suite 210, Phoenix, Arizona 85018-7256 · (602) 912-8456 · FAX: (602) 912-8452

http://www.state.az.us/id

Contact: Gregory Y. Harris
Executive Assistant Director
602/912-8456 (phone)
602/912-8452 (fax)

Press Release No. 1998-3

FOR IMMEDIATE RELEASE
June 29, 1998

DEPARTMENT OF INSURANCE IMPLEMENTS PROCEDURES TO PERMIT CONSUMERS TO APPEAL DECISIONS BY HEALTH CARE INSURERS

John A. Greene, Director of the Arizona Department Of Insurance, announced today the availability of new rights for Arizona consumers who disagree with their health care insurer's decisions regarding coverage issues, including whether a procedure is medically necessary.

Beginning July 1, 1998, a new Arizona law requires each health care insurer to have an appeals process available to individuals covered by the insurer.

The law, sponsored by State Senator Ann Day, also prohibits a health care insurer from restricting a doctor or other health care provider from discussing health care issues, medical needs, treatment options and health care risks or benefits with patients.

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Each insurer's appeals process generally must include at least four separate levels of review. A consumer may ask for the review process to start if an insurer denies a request for a service or request for the payment of a claim. The levels of review include:

- Expedited Medical Review for emergency medical cases, to be completed within one business day of the request for review.
- Informal Reconsideration, to be completed within 30 days of the request for review.
- Formal Appeal, to be completed within 30 days of the request for review, or 60 days in the case of denied claims.
- External Independent Review, generally to be completed within 30 days of the request for review.

Cases that reach External Independent Review will be evaluated by the Department to determine if the request includes questions about whether, from a contractual standpoint, the policy covers the claim or requested service. Even if a policy covers a particular treatment or condition, an insurer may deny coverage because it believes the treatment is not medically necessary in a particular case. Cases that involve questions of medical necessity will be referred to one of over 125 independent, medical professionals to review and determine the appeal presented by the consumer.

A consumer may begin the appeal process by using the process adopted by the health insurer that provides the consumer's health care coverage. Under the new law, insurers must furnish each consumer with an information packet. Each consumer should receive a copy of the packet when the law takes effect and when the consumer files an appeal. This packet describes the insurer's appeal process, including the specific employees of the insurer to contact with questions about the insurer's appeals process.

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Greene stated that "The Legislature's intent in passing the new law was to positively impact access to and quality of health care delivered to Arizona consumers. The Department of Insurance is committed to ensure the smooth implementation of the new appeals process. The appeals process complements the Department's existing duties to monitor and enforce compliance with the insurance law for the benefit of Arizona consumers."

Greene also noted that Arizona's appeals law might be unique. He stated that "The new law applies not only to HMOs, but also to indemnity plans that have increasingly implemented managed care techniques, such as prior approval of certain medical procedures." Greene also pointed out that the new law does not apply to self-funded employer sponsored health plans, also known as ERISA plans. It also does not apply to workers' compensation insurance, Medicare or AHCCCS plans.

After implementing this new law, the Department will continue to provide assistance to consumers with questions about health care insurance. "This new law exists to provide each consumer with a process to question a health care insurer's decision, and the Department will respect that process. At the same time, the Legislature clearly stated that the adoption of this new process does not limit the Department's duty to investigate and sanction violations of the insurance laws," Greene stated.

"We will monitor compliance with the new law to ensure that insurers adopt the required appeal procedures and that insurers make these procedures available to the public," said Greene.

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The Arizona Secretary of State published a list of the External Independent Reviewers in the June 5, 1998, Arizona Administrative Register. This list may also be obtained from the Department's website, along with an outline of the appeals process. The address for the Department's website is http://www.state.az.us/id.

A copy of the Department's summary of the appeals process also accompanies this press release.

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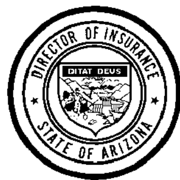
JANE DEE HULL
GOVERNOR



JOHN A. GREENE
DIRECTOR

ARIZONA DEPARTMENT OF INSURANCE

2910 North 44th Street, Suite 210, Phoenix, Arizona 85018-7256 · (602) 912-8443 · FAX: (602) 912-8453

OUTLINE OF THE HEALTH CARE APPEALS PROCESS IN ARIZONA

This brochure 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 insurer. If you file a complaint with the Department of Insurance related to a claim denial or a service denial that is subject to the appeals process, the Department must require you to pursue the appeals process at your insurer. The Department will not otherwise address your complaint during the appeals process, except to the extent your complaint alleges an independent violation of the Insurance Code other than the denial of your claim or request for service.

What is the health care appeals process?

Beginning July 1, 1998, Arizona law requires health insurers, HMOs, dental plans, prepaid dental plans and vision plans to provide their insured members with a way to appeal denied claims or denied services. The appeals process is available to Arizona residents who have claims or services denied from and after July 1, 1998. A "denied claim" is when you have already received care, submitted a claim, and the insurer has denied the claim. A "denied service" is when the plan refuses to authorize a service that is covered by the plan, such as a referral to a specialist, or the plan refuses to pre-authorize any treatment or procedure that you or your doctor believe is medically necessary and covered by your policy. Please keep in mind that the appeals process will normally *not* occur unless you have specifically requested that your insurer or plan reconsider its decision to deny a claim or service. The appeals process consists of the following 4 levels of review:

1. Expedited Medical Review
2. Informal Reconsideration
3. Formal Appeal
4. External, Independent Review.

Expedited Medical Review

Expedited Medical Review will normally *only* apply to denied services when your doctor (or treating provider) certifies in writing that delaying the needed health care service could cause a significant negative change in your medical condition. The insurer or health plan must make a decision within 1 business day after reviewing your doctor's certification and any supporting documentation, and notify you and your doctor of the decision. If your insurer or health plan still believes that it should not cover the requested service after the Expedited Medical Review is completed, you may then make a Formal Appeal, which is described below.

Informal Reconsideration

Informal Reconsideration is the first step in the appeals process for denied services when you do not qualify for Expedited Medical Review. You may request Informal Reconsideration by calling, writing or faxing your request to your insurer. You have up to 2 years after your insurer denies your request for a covered service to request an Informal Reconsideration. The insurer has 30 days to make a decision and notify you and your doctor or treating provider of that decision. For denied claims, some insurers may allow you to go through the Informal

Reconsideration process, or they may require that you go straight to a Formal Appeal. If the insurer still denies your request for service (or claim, if applicable) after the Informal Reconsideration is completed, you may then make a Formal Appeal.

Formal Appeal

If your insurer denies your request for a covered service after either an Expedited Medical Review or Informal Reconsideration, you may make a Formal Appeal. You have 60 days following the completion of the Informal Reconsideration of a denied service to request a Formal Appeal. You may also request that your insurer review denied claims at the Formal Appeal level up to 2 years after the last denial occurred. For denied services, your insurer has 30 days to make its decision. For denied claims, the insurer has 60 days to make its decision and notify you of the decision. The insurer will also notify your doctor and treating provider. If the insurer still denies your request for service or a claim for a service, you can then request an External, Independent Review.

External, Independent Review

You have 30 days after your insurer notifies you that your Formal Appeal was denied to request an External, Independent Review. For cases involving an issue of medical necessity, your insurer will send a copy of all relevant medical records and any supporting documentation used to make its earlier decision to an external, independent reviewer. This external, independent reviewer must generally be a doctor who is board certified or board eligible in his or her specialty. The reviewer may not have any direct financial interest in your case. Your insurer has 30 days from when it receives your request for an External, Independent Review to notify you and your doctor (or treating provider) of the reviewer's decision.

For cases involving denied claims for a covered service, the insurer must send a copy of your policy (or similar form), all relevant medical records, and a description of the basis for its decision to the Department of Insurance. The Department has 5 business days to review the information provided and determine if the denied claim is covered under the policy. If the Department is unable to determine if the claim is covered under the policy, we may then have the case sent to an external, independent reviewer.

Both the external, independent reviewer's decision and the Department of Insurance's decision are legally binding on the insurer and you, even if you or the insurer disagrees with the decision. Either you or the insurer may go to court following the completion of the External, Independent Review.

What doesn't qualify for the appeals process?

Those with coverage through a Medicare HMO, a federal employee plan, or any self-funded or self-insured plan are not eligible to participate in the appeals process described in this brochure. Worker's Compensation claims and disputes are also not eligible for this appeals process. These other plans normally do have an appeals process of some kind that you may use, but the appeals process in those other plans will probably be somewhat different from what is described in this brochure. Issues concerning how you were treated by a provider, benefit reductions due to usual and customary charge limitations, deductibles, and coordination of benefits issues are also not eligible for health care appeals. If you merely have questions regarding your plan, you should call the member services department of your insurer.

Helpful Hints

If you decide to file an appeal with your insurer, make sure to include as much supporting documentation as possible that shows why the denied service or claim should be covered. When filing an Expedited Medical Review, make sure you also include the doctor's certification that delaying treatment will negatively impact your medical condition. 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 insurers. There can be some variation from company to company. Please refer to the Health Care Appeals Information Packet available from your insurer for more specific details regarding how your insurer handles appeals.