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National Association of Independent Review Organizations

Know Your Healthcare Appeal Rights:

A Q&A on the Health Insurance Appeals Process for Consumers

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Introduction

Today there are increasing pressures on health plan claims managers to make the right decisions, not only for consumers, but also to keep healthcare costs, premiums and co-payments down. In addition, claims managers are working to comply with the new healthcare reform legislation. The Patient Protection and Affordable Healthcare Act and the Health Care and Education Reconciliation Act of 2010 (PPACA)[1] were designed to enhance consumer rights and protections regardless of whether the consumers are members of a fully-funded[2] or a self-funded (self-insured)[3] plan.

Under the 2010 healthcare legislation, new rules have been put in place to strengthen the appeal process and to make it easier for consumers covered by a fully funded (fully-insured) or self-funded plan[4] to challenge health plan denials of coverage for treatment and services. Despite these changes, the process for an appeal is not always clear. Not only do appeal processes differ between fully-insured and self-funded plans, they vary from state to state and from health plan to health plan.

Generally, there are three steps in a standard appeal process: a first level internal appeal; an optional internal second level internal appeal; and a third level (external) appeal.[5] Under the current regulations, the health insurance carrier may conduct internal appeals. Only the final external appeal must be performed by an independent review organization (IRO).[6] Nevertheless, as an emerging best practice, many health insurers and other payer organizations are beginning to use IROs at all levels of appeals to avoid conflict of interest concerns.[7]

[1] The Patient Protection and Affordable Healthcare Act and the Health Care and Education Reconciliation Act of 2010 make up the Healthcare Reform Act of 2010.

[2] A fully-funded healthcare plan is one in which the employer purchases group health insurance and pays a per employee premium to cover its employees and their dependents.

[3] A self-funded plan is a health insurance agreement whereby an employer acts as the insurer and provides health or disability benefits to employees with its own funds.

[4] The United States Department of Labor, Employee Benefits Security Administration (DOL-EBSA) under the federal Employment Retirement Income Security Act (ERISA) govern most employer self-funded plans, which are therefore not subject to state laws and regulations. To review a flowchart of the ERISA process, go to http://www.acatoday.org/pdf/erisaflowchart.pdf.

[5] Please see the glossary for the definitions of internal and external appeals.

[6] The PPACA supports older legislation, which says that a health plan must have at least one and not more than two levels of internal review. Whether a plan has one or two levels of internal appeal is noted in the membership handbook or the contract for the plan.

[7] Please see the Glossary for a definition of IRO and the "Independent Review Organizations" section for more about IROs.

An internal appeal is a first request to have your healthcare plan reconsider your claim after it has been denied. Under the terms of some health plans, you may also have to request a second-level internal review.

Once you have exhausted the internal appeal process that is determined by your healthcare plan, you can request an external appeal. In an external appeal, your claim goes for an independent review of the denied claim. An independent clinical reviewer who is not employed by your health plan conducts the review. Independent reviewers include board-certified or licensed physicians, physician advisors, allied clinicians, and other healthcare professionals.

Depending on whether you are insured under a fully-funded or self-funded healthcare plan, different laws regulate the appeal process. For ***fully-funded*** plans, your state regulates external appeals. For ***self-funded*** plans, ERISA under the Department of Labor (DOL) regulates external appeals. Please see Table 1 (on page 6) for some of the differences between the two plans.

Except in a few states, the appeal process generally costs nothing to file.[8] It does, however, require a concerted effort on your part to understand how the process works and to see the appeal through to the end.

The National Association of Independent Review Organizations (NAIRO) has created this primer to help you, as a healthcare consumer, better understand your rights under the healthcare appeal process. It is presented in a question and answer format so that you can easily find the information you need. To further assist you, a brief glossary of terms and a list of resources are included at the end of this paper.

Common Questions about Healthcare Appeals

General Questions on Appeals

1. *Where can I find out how to file an appeal?*
2. *What is the difference between an "internal" and an "external" appeal?*
3. *Where can I find this information in my insurance plan handbook?*
4. *Can I request an appeal for any type of insurance denial?*
5. *What are the benefits of filing an appeal? What if the denial is upheld?*
6. *When a treatment is denied, what are my appeal options?*
7. *What is the difference between a standard review and an expedited review of an appeal?*
8. *How long does an appeal take?*
9. *Does an appeal cost anything?*

Internal Appeals

10. *The letter from the insurer said I have the right to appeal: What does that mean?*
11. *What information do I need to provide for an internal appeal?*
12. *Who regulates internal appeals?*

[8] A few states, such as Kentucky and Wyoming, require a modest $25 fee to file an appeal. Go to www.naic.org/state_web_map.htm to find out if your state has a fee.

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External Appeals

13. *The denial letter from my healthcare insurer says that I have exhausted or completed the internal appeals process, and it says something about external appeal or independent review: What is an external appeal?*
14. *Who can request an external appeal?*
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Table 1: Overview of Fully-funded versus Self-Funded Appeals

Question	Fully-funded	Self-Funded
Who decides on the internal appeals process?	Your health plan provider.	Third-party administrator (TPA) working on behalf of the employer offering the self-funded plan.
Who conducts internal appeals?	Often they are conducted by the clinical reviewers or staff employed by your health insurance provider or an IRO.	Clinical reviewers working for a third-party administrator or an IRO.
Who regulates external appeals?	These are regulated by your state insurance commissioner. There are currently four states without state regulated reviews: Alabama, Mississippi, Nebraska and North Dakota; these states must follow federal external review requirements.	Regulated by ERISA under the U.S. Department of Labor.
Who conducts external appeals	An IRO approved by your state insurance commission.	IROs accredited by URAC or other credentialing organization.
What does it cost me to make an appeal?	There is no cost for internal appeals. Some states have a minimal charge that can be refunded if your external appeal is successful.	There is no cost for appeals.
Where can I go to find out about the appeal process?	Plan handbook. Human resources department. Plan customer service desk. Plan website. State insurance commission. State insurance commission website. (Please see the Resources section)	Plan handbook. Human resources department. TPA. United States Department of Labor Employee Benefits Security. Administration (DOL-EBSA) website.

Answers to Questions about Healthcare Appeals

General Questions on Appeals

1. Where can I find out about how to file an appeal?

If you have a ***fully-insured*** health insurance plan, start by consulting your plan handbook for information about internal and external appeals. The member handbook for your health plan should list all the requirements for an appeal. It should answer many questions that you have regarding the appeal process. Contact your human resources department and request information about the internal and external appeal processes. Ask them about the process for submitting an internal or an external appeal, what information is needed, and any deadlines or schedules you must meet. Some health plans also make this information and the needed forms available on their websites. In addition, most state Departments of Insurance also have consumer help lines and websites to help explain the appeal process. (Please see the Resources section.)

If your insurance is a ***self-funded*** plan, consult your plan handbook. If you need more information, contact your human resources department or third-party administrator and ask about the internal and external appeal procedures. The United States Department of Labor Employee Benefits Security Administration (DOL-EBSA) or its website at www.dol.gov/ebsa can answer questions regarding self-funded plans and their appeal procedures. (Please see the Resources section.)

For external appeals, most states also have consumer help lines and websites to help explain the appeal process. In addition, you may also contact your state Department of Insurance or go to its website and look for consumer information about healthcare grievances and complaints.[9]

For more general information on the independent review process, please visit the NAIRO website at www.nairo.org.

2. What is the difference between an "internal" and an "external" appeal?

An internal appeal, or internal review, is conducted "in-house" by the health plan (or TPA) using its own physician advisors, medical directors or other healthcare professionals. As an emerging best practice and to decrease any concerns regarding conflict of interest, many plans now outsource their internal appeals to an IRO to ensure that they have access to clinical specialists who are up-to-date on medical treatments and practices. You should ask your health plan if they use IROs for internal appeals. (For more information about IROs, please read the Independent Review Organizations section below.)

[9] For a list of state insurance departments, go to http://www.naic.org/state_web_map.htm.

Once you have exhausted the internal appeal process, which usually consists of at least first and, if required, a second level appeal, you may request an external appeal, which is sometimes called an external or independent review. However, some states and plans require a preliminary review to ensure that you are eligible for an external review. The preliminary review usually involves determining whether you were a member of the plan when the treatment or service at issue occurred; whether the treatment or service is a covered benefit; and whether the internal appeal process has been completed.

External appeal allows the healthcare consumer the opportunity to have any denied treatments or services reviewed by an IRO. The IRO uses board-certified, licensed independent physicians and clinicians who have expertise regarding the treatment/service in question.

Fully-insured plans are required to inform you of your external appeal rights, including the process for requesting an external appeal. This information is contained in your insurance handbook and in your denial letters. If you have any questions regarding the external review process, you can contact the plan provider directly or your state Department of Insurance for further information.[10]

Because DOL-EBSA governs ***self-funded*** health plans, plan members must follow ERISA claim procedures. For more details, please see the Resources section.

3. *Where can I find appeal information in my insurance plan handbook?*

By law, information about external reviews must be mentioned in your insurance handbook and your denial letters. It may be hard to find in your handbook, however. Consult your member handbook table of contents or index. Otherwise, contact the customer service department of your insurance provider or TPA and ask about the process for initiating an internal or an external review. You may also want to contact the DOL-EBSA for self-funded plans or your state Department of Insurance for fully-funded plans for more information. (Please see the Resources section.)

4. *Can I request an appeal for any type of insurance denial?*

Even if your health plan specifically excludes[11] a treatment, you can request an appeal. However, please keep in mind that both internal and external appeals decisions

[10] The four states without state regulated reviews — Alabama, Mississippi, Nebraska and North Dakota — must follow the federal external review requirements.

[11] Exclusions are treatments, drugs or devices that the health plan does not cover. These are spelled out in your plan handbook. Typically, these treatments are considered to be purely cosmetic and experimental/investigational, or they may be the subject of a clinical trial. Clinical trials involve a limited number of individuals with specific health conditions and are conducted in four phases to help medical scientists understand their benefits, risks and side effects. Find more information at http://clinicaltrials.gov/ct2/info/understand.

are determined based on the medical evidence regarding whether the treatment or service is medically necessary for your situation, as well as the medical policy that stipulates what is covered.

Some states allow for coverage reviews. For these types of reviews, the reviewer, who is usually an attorney expert in healthcare, determines if the treatment or service is covered by the health plan. Oftentimes, a coverage review is conducted simultaneously with a clinical review that assesses the medically necessity of the claim.

5. *What are the benefits of filing an appeal? What if the denial is upheld?*

If your claim was denied, you cannot receive coverage of the treatment or service unless you initiate the process for an internal or an external appeal. Your only cost is the time it takes to research and manage the appeal process. If you make it to the external review level and the IRO overturns your denial, this decision is binding to the insurer.

Regardless of your plan type (fully-funded or self-funded), please keep in mind that, at the external appeal level, an IRO will either approve or reject your claim based on the objective medical evidence. If the IRO denies your internal appeal, you still have legal recourse. Most states require that this information be included in the final external review notice. However, you are responsible for the costs of pursuing legal action beyond the external appeal level.

6. *When a treatment is denied, what are my appeal options?*

The appeal process starts with an internal appeal as defined by your health insurer or TPA. Health plans must provide members both an internal (self-reviewed) and an external (state/federal regulated) appeal process. The internal appeal may have no more than two steps: a first-level and a second-level (if required) internal appeal. In many health plans, internal appeals are reviewed by clinicians and staff who are employed by the health plan. The outcome of an internal appeal, however, does not bind either you or the health plan.

While not required by the new legislation, many health plans use IROs for their internal reviews as a best practice. In using this best practice, health plans turn to IROs to conduct internal medical appeals based on the latest medical evidence, the medical necessity criteria and your health plan contract.

Internal appeals are not binding. The outcome of an external appeal review is binding for you and your health plan. After the external appeal, you still have the option to pursue legal action at your own expense. This information is usually contained within your external review notice.

7. *What is the difference between a standard review and an expedited review of an appeal?*

Most health plans conduct standard reviews when the review of a claim is not an emergency and does not threaten your health or life. Some states let you bypass the internal review process if your health is in jeopardy, and let you go directly to an expedited external review process. An expedited review is necessary when a delay in service would jeopardize your health or life.[12] Oftentimes, expedited reviews are needed for services that are subject to pre-authorization by your health plan.[13]

Regardless of your type of plan (fully-funded or self-funded), if not having a treatment jeopardizes your health or your life, you may request an expedited external review, which bypasses the health plan's first level internal review.

8. How long does an appeal take?

Because there is no consistent time-frame for internal appeals, it may take you considerable time to move through the two levels of internal appeal and then to an external appeal. If you have an emergency and qualify for an expedited internal or external appeal, you may have a response within days.

Internal appeal response times are set by the health insurer for ***fully-funded*** plans. Most plans state a specific amount of time in which you have to initiate an appeal. It may vary from plan to plan.

Self-funded plans follow the DOL-ESBA regulations. You must submit your request for an internal appeal within 60 days of receiving a denial.

Internal appeal response times are set by fully-insured plans. They are set by your TPA for self-funded plans and follow the DOL-ESBA regulations. In either case, consult your plan handbook, your human resource department or the customer service department of your health plan for more detail.

For external appeals, please read Question 19, "How long does an external appeal take?"

9. Does an appeal cost anything?

There is no charge for an internal appeal and you have the right to request one.

Your only cost of an external appeal involves the time spent in contacting your health plan to determine the process for requesting an appeal and the time it takes you to request and manage your appeal. Your health insurer is responsible for paying any other fees for the review. Some states (Wyoming, Kentucky and West Virginia at this time) require a modest filing fee of $25 to file an appeal, and the fee may sometimes be waived or returned.

Internal Appeals

10. The letter from the insurer said I have the right to appeal. What does that mean?

An appeal is available whenever your health plan denies your coverage request. The

[12] One example of a situation that would necessitate an expedited review is an in utero (in the womb) surgery for the fetal abnormality of spina bifida, which was recently found to be a successful procedure if performed at the right time of the pregnancy. However, for an expedited review, your physician may need to fill out an expedited review form.

[13] Each state and the PPACA set their own time requirements for standard and expedited appeals.

reasons for denial include the following: the treatment or service is medically unnecessary, is inappropriate, is not covered under your plan's medical policy, or is experimental or investigational.

The appeal process has three parts: an internal appeal, which may include first and second-level appeals, and an external appeal. An internal appeal is the process of asking your health plan to reconsider your claim after it has been denies. In most cases, you must complete your plan's internal appeal process before being eligible for an external appeal.

Should your health plan decline your claim during any level of internal appeal, you still have the right to an external appeal, which is administered under state (for fully-insured plans) and federal guidelines (for self-funded plans and states without external appeal regulations). An external appeal always involves an IRO. Generally, you cannot request an external appeal until you have exhausted or completed your plan's internal appeal process, which usually involves first and second level reviews.

For ***fully-funded*** health plans, 46 states now offer and regulate external appeals for fully-insured healthcare plans.[14] During the external appeal stage, you may request that your health plan send your case out for independent review by an IRO. In most states, you are provided an opportunity at the external level to submit additional information if you feel it is relevant to your appeal. You should contact your state Department of Insurance if you have any questions about this process. Most states have consumer help lines and information on their websites to help consumers navigate this process. In some life-threatening or emergent cases, you can bypass the first level appeal. This is called an expedited review. (Please see Question 7 for more on expedited reviews.)

Members of ***self-funded*** plans who request an external review must follow the DOL-ESBA and ERISA guidelines for review. (Please see the Resources section.) For self-insured plans governed by ERISA, members should consult their plan handbook for appeal procedures. The DOL-EBSA can answer questions regarding self-insured plans and the appeal procedures.

During external appeal, an IRO reviews your claim based on the medical evidence. NAIRO members are state-certified and are accredited by URAC to provide an evidence-based, unbiased review of your claim.[15] The federal regulations covering self-funded plans and the state regulations covering fully-funded plans require an IRO be certified by or meet the standards required by an accreditation organization.

Many insurance companies have adopted the use of IROs for the review of internal appeals as a best practice. This helps avoid conflicts of interest at all stages of the

[14] The four states without state regulated reviews — Alabama, Mississippi, Nebraska and North Dakota — must follow the federal requirements for appeals.

[15] While no specific certifying organizations are named by the new legislation or by states, URAC is the only organization that accredits IROs at this time.

appeal process. Ask your insurance provider if/when they use IROs to review appeals.

Whether you have a fully-funded or a self-funded health plan, and no matter what level of appeal you are pursuing, work with your human resource department, or the customer service desk of your health plan (or TPA) to determine the appropriateness of your appeal and to understand the process for filing your appeal.

11. What information do I need to provide for an internal appeal?

You must follow the directions set forth by your health plan or TPA regarding how to apply for an internal appeal. For an internal review, your health plan or TPA will need your medical records, which your doctor can provide. Generally, you or your representative must contact your plan or TPA to request an internal appeal.

12. Who regulates internal appeals?

Internal appeals for ***fully-insured*** plans are self regulated by the health plan. On the other hand, ***self-funded*** plans are controlled by your TPA, but they must follow the DOL-ESBA regulations.[16]

External Appeals

13. The denial letter from my health insurer says that I have exhausted or completed the internal appeals process, and it says something about external appeal or independent review: What is an external appeal?

Your letter should provide some of the information about your rights to an external appeal and how your health plan (or TPA) handles that process.

Members of ***fully-insured*** health plans who choose to pursue an external appeal must make a written request to their plan. Their health plan then begins the external review process by collecting all of the documentation related to your claim. Depending on the state, your health plan or your state Department of Insurance will select the IRO that will perform the external review. Most states have an approved list of IROs to use and a method for selecting and assigning your case.

If you are covered by a ***self-funded*** plan, you must also make a written request to your human resources department or TPA. (Please see the Resources section for more details.)

14. Who can request an external appeal?

State and federal regulations allow eligible enrollees who receive a health plan claim denial letter and who have exhausted the internal appeal process to request an external appeal. Some states and some plans require a preliminary review to ensure that you are eligible for an external review. The

[16] The legislation also requires legal specialists to review appeals, but the details have yet to be sorted out.

preliminary review usually involves determining if you were a member of the plan when the treatment or service at issue occurred; whether the treatment or service is a covered benefit; and whether the internal appeal process has been completed.

15. Are there any eligibility requirements to request an external appeal?

In general, health plans require the following conditions to request an external review:

- You must be a covered member at the time you requested the service.
- Your plan must cover the treatment. In addition, you must be current with your healthcare premiums.
- You must have exhausted the internal appeal process of the healthcare plan.

A few states designate a nominal limit on the treatment for making an appeal. (For example, the denied treatment must exceed $300.)

16. What steps do I need to take to file an external appeal?

Once you have exhausted the internal review process, you should consult your member handbook or contact the customer service department of your healthcare provider or TPA and ask about the external review process. Information and appeal filing instructions should be included in your denial letter. In addition, many health plan websites have external review information and forms that you can download.

17. Does my state offer external appeal?

In 46 states, the respective state Department of Insurance regulates how ***fully-insured*** health plans must conduct external reviews. If a state review process is available, a fully-insured group health plan must comply with that process. If the state does not have a defined process, the plan must comply with the federal external review process. Because they have no state-defined external review process, North Dakota, Nebraska, Mississippi and Alabama fall under the federal regulations.

States insurance regulations do not apply to external appeals for ***self-funded*** plans. For self-funded plans, external reviews are regulated by the federal government by ERISA and the DOL.[17] (Please see the Resources section.)

18. How long do I have to file an external review after my denial?

According to the National Association of Insurance Commissioners (NAIC), you have up to four months to make a claim after a denial. The 2010 healthcare legislation suggests that both fully-funded and self-funded plans follow this model. Please review Question 1 and the Resources section for more detail about how to find answers.

[17] Because ERISA, a federal organization working with the Department of Labor, governs most self-insured health plans, your state has little jurisdiction in this matter.

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19. How long does an external appeal take?

For external appeals, the 2010 healthcare legislation attempts to provide more uniformity across both types of health plans. It offers the National Association of Insurance Commissioners (NAIC) Uniform Health Carrier External Review Model Act standard as a blueprint for external reviews to follow. Based on the NAIC Model Act, an IRO must respond to fully-funded and self-funded external appeals within 45 days of your request for an external appeal. This process must also provide an expedited review for emergency services and must respond within 72 hours after receiving the request.

Because states regulate ***fully-funded*** heath plans' response times to external appeals, you should check with your state of residence to learn these times. Alternatively, you may also ask your human resources department, review your plan policy, check the information on your plan's website or speak with your plan's customer service department.

Enrollees in ***self-funded*** insurance plans have 180 days from the date they receive a denial letter to request an external appeal. Usually, the plan has just 45 days from the "date of assignment" to make a decision about a DOL-EBSA (ERISA) appeal. However, these regulations allow insurance plans two 30-day extensions for good cause. You may file your appeal with the plan administrator, the plan sponsor, or the Pension and Welfare Benefits Administration of the United States Department of Labor.[18] The self-funded plan and the IRO must provide written notice of the final external appeal decision within 45 days of receiving a request for an external appeal. The notice must be delivered to you and your plan. However, the new legislation looks to the NAIC model standards for response times, and these are different from the DOL-EBSA standards, which state that you have 60 days to respond.

20. Who regulates external appeals?

For fully-funded ***health*** plans, external appeals are mandated and regulated by your state and must use an unbiased third party, usually an IRO, to avoid conflicts of interest and to provide a fair review.

In contrast, ***self-funded*** health plans are regulated by federal laws. The DOL-EBSA governs self-insured health plans. (Please see the Resources section.) Consumers who are members of self-funded plans must follow ERISA claim procedures for both internal and external appeals.[19] You should refer to your self-funded plan member handbook for the proper appeal procedures.

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[18] For details about this process, please see http://www.dol.gov/ebsa/publications/filingbenefitsclaim.html.

[19] Please see the Glossary and Resources sections for more about ERISA.

Common Treatment Questions

21. My doctor said I need a treatment, but my insurer will not provide coverage for it: Can I appeal?

Your health plan can decline a treatment or service for a range of reasons, including determining it is outside the current standard of care, the treatment is inappropriate or the treatment is in a specified phase of a clinical trial.[20] Other reasons include the following: the treatment is medically unnecessary, the treatment is excluded by the plan, the treatment is experimental or investigational, or, in some cases, the treatment was rendered out-of-network by doctors or hospitals that are not contracted with your insurer.[21]

Regardless of the reason, you can make an appeal. For example, even if your policy lists specific treatments as experimental, investigational or inappropriate, you may still have justification for an appeal based on medical necessity and can request an internal appeal. Nonetheless, the decision about your claim will be based on medical evidence, medical necessity and the current standard of care. However, the standard of care is a moving target; this means that sometimes the plan language is out of date and may exclude treatments that are now accepted as standard medical practice or treatments that were once considered experimental or investigational but are now accepted practice.

22. My doctor said I needed to stay in the hospital and now my insurer will not pay for it: Can I appeal?

Using accepted scientific evidence and recognized clinical guidelines, health plan medical policies designate certain treatments as outpatient care that does not require hospitalization. For example, most plans now consider hernia repairs to be outpatient surgery.

Following similarly recognized clinical guidelines, health insurers may assign average lengths of hospital stay for some conditions and treatments and refuse to pay for further time in the hospital. Also, you can work with your doctor to submit an appeal based on the medical necessity of the longer hospital stay. (Please refer to Question 1 and the Resources section about where to find more information.)

23. What if my policy excludes coverage for a treatment (for example, weight loss surgery)?

You may appeal claims in which the treatment is considered medically necessary. This is important for consumers, because medical knowledge is continually changing and, oftentimes, it takes the insurance plan language time to catch up with these changes. Treatments once considered risky,

[20] Clinical trials involve a limited number of individuals with specific health conditions and are conducted in four phases to help medical scientists understand their benefits, risks and side effects. Find more information at http://clinicaltrials.gov/ct2/info/understand.

[21] Please see your health plan policy (or contract) for definitions of these terms.

inappropriate, experimental or investigational often become mainstream medical practice.

Additionally, in some states, coverage disputes are eligible for independent review. In such cases, an attorney with expertise in healthcare reviews the claim and decides if the treatment or service is covered by the healthcare plan. Oftentimes, this review is conducted in parallel with a clinical review that looks at the medical necessity of the claim. Consult your plan handbook or the customer service department to find out if this applies to your plan.

If your ***fully-funded*** or self-funded health plan policy specifically excludes the coverage of a treatment, such as weight loss surgery, in most states the IRO conducting the external appeal must adhere to the policy language.

Independent Review Organizations

24. What is an independent review organization?

An independent review organization (IRO) is a third party organization that is capable of reviewing your claim objectively, because it is not affiliated with the health plan. Leading IROs are accredited by URAC and must meet rigorous standards for objectivity and conflict of interest and must apply scientific (medical) evidence, confidentiality, and credentialing standards. In fact, the PPACA requires health plans to use URAC-accredited IROs for external reviews.

The IRO used by your health plan will choose an appropriate clinical reviewer (or reviewers, if necessary or required by state or federal law) to review your case. The IRO chooses a clinical reviewer with expertise in the specialty your claim involves. Depending on your claim, the assigned reviewer might be a physician or clinician who is board-certified and licensed in the same or similar medical or clinical specialty at issue in your claim. This clinical reviewer takes an evidence-based approach when making a determination and must follow any applicable health plan documents and clinical criteria governing your benefits. In some cases, the IRO may consult with an insurance expert or an attorney when the case involves a non-medical or coverage issue.

Many states publish a list of approved IROs on their state insurance websites. (Please see the Resources section.) A list of accredited IROs is at www.nairo.org under the “Find an IRO” tab.

25. What documents do I need to provide to help the IRO make an external review decision?

The insurer is required to provide the IRO with all of the medical records and documentation relevant to your claim. Additionally, during the external appeal process, you may provide the IRO with any information that you believe will support your claim. This may include your medical records, a letter from your doctor, or even research articles from peer-reviewed medical journals.

26. Who performs the review for the independent review organization?

The accredited IRO will be selected to review your claim by your health plan for ***self-funded*** external appeals and by the state for ***fully-insured*** external appeals. The IRO, in turn, will choose an appropriate independent board-certified physician or clinical reviewer (or reviewers, if necessary or required by applicable law) to examine the case. The IRO is responsible for choosing a reviewer in the same or similar specialty as the issue in your claim. Furthermore, URAC standards prevent the healthcare plan provider from directing the IRO toward any specific clinical reviewer so as to ensure that the review is completed independent and without conflict of interest. The selected clinical reviewer must take an "evidence-based" approach when reviewing your case and must follow the plan policy (or contract) and any other applicable criteria governing your member benefits.

27. How does an IRO make a decision?

An IRO clinical reviewer assesses the procedure, treatment or medication in question along with all of the documentation and other information you and your insurer may have provided. The reviewer also considers the medical policy and applies the appropriate clinical criteria and any relevant medical or scientific evidence.

About NAIRO

NAIRO works to promote the value and integrity of the independent medical review process. Its member organizations embrace an independent, evidence-based approach to medical review so as to resolve coverage disputes between enrollees and their health plans. For more information, please visit www.nairo.org.

Glossary

Accreditation (accredited) — is a process in which an impartial organization, such as URAC, reviews the credentials of individuals, such as physicians, and organizations' operations so as to ensure that their conduct and quality are consistent with the accepted national standards.

Appeal — the act of responding to a health plan's denial of service, because it claims the treatment is medically unnecessary, inappropriate or is experimental or investigational. This is guaranteed by law.

Clinical reviewer — an unbiased, board-certified and accredited physician or allied healthcare practitioner who has the training and experience to review your claim based on the medical evidence. The reviewer makes an evidence-based determination.

Clinical trials — clinical trials are conducted in four phases and help scientists understand how well a treatment or a drug works (or does not work), including its risks and side effects. Clinical trials study a limited number of patients who have a specific health problem. Oftentimes, clinical trails are excluded from health policies. Some states may regulate which phase(s) of clinical trials your health policy must cover. (Please see the Resources section.)

ERISA — the federal Employee Retirement Income Security Act, ERISA, is a federal law that sets the minimum standards for most voluntarily-established pension and health plans in the private industry so as to provide protection for individuals in these plans. The Employee Benefits Security Administration (EBSA), a division of the United States. Department of Labor (DOL), administers ERISA. The organization is meant to be a safeguard to protect the funds of self-funded (self-insured) plans and to deliver them in the best interest of qualified plan members. In addition, ERISA prohibits unfair practices in plan benefits for plan members.

Evidence-based review (evidence-based medicine) — the process of applying the best available scientific and clinical medical evidence and using it to make determinations about patient care. In doing so, this process balances the strength of the evidence, including the treatment risks against the benefits of treatment to determine whether a claim will be approved.

Exclusions — treatments, services, procedures, drugs or devices that the health plan does not cover are exclusions. These are spelled out in your plan handbook and often include treatments that are considered to be purely cosmetic, experimental, investigational, or the subject of a clinical trial.

Expedited review — when the standard time-frame for a review of a treatment jeopardizes your health or your life and your physician can provide proof of this, you may bypass the health plan's internal review cycle.

Experimental treatment — in a clinical study, a group of patients is exposed to one component that the control group is not. Researchers then look for any differences between the experimental treatment and the control treatment by assuming that these differences are probably caused by the component they are testing.

External appeal (external review, independent review, third-level review) — is a request to your health plan for an independent review of the denied treatment, once you have exhausted the appeal processes within your health plan. An independent and board-certified clinical reviewer who is not employed by your health plan conducts the review. This is the same as third-level appeal.

First-level appeals — please see internal appeal.

Fully-funded (fully-insured) health plan — is a health insurance plan in which the employer purchased a group health insurance plan and pays a per-employee premium to cover its employees and their dependents. The group health insurance plan assumes the risk. Fully-insured health plans are subject to state laws and regulations.

Healthcare Reform Act of 2010 —the Patient Protection and Affordable Health Care Act (PPACA) and the Health Care and Education Reconciliation Act of 2010 together make up this act.

Independent review — this is the same as an external appeal or an external review.

Independent review organization (IRO) — this is a third party organization that objectively determines the medical necessity and appropriateness of healthcare that has been delivered or has been proposed. The IRO is responsible for assigning the case to an appropriate specialty reviewer who certifies that he/she has no conflict of interest. An IRO provides a review whenever your health plan denies coverage or when a health plan maintains that the treatment is medically unnecessary, inappropriate, or experimental or investigational. IROs may also be involved in the preapproval of treatments.

Internal appeal (internal review, first-level review or appeal, second-level review or appeal) — internal appeals may have up to two steps: a first- and a second-level appeal. When a treatment is denied by your health plan, a first-level appeal is a request that the health plan again review your claim using a physician with the same or similar specialty. If your first-level appeal is denied, then you may request a second-level appeal. Healthcare plans require that you exhaust their internal appeal process before requesting an external appeal. One exception is a request for an expedited review. (Please see expedited review.)

Investigational treatment — this is a new drug, device or treatment that is under test in a clinical research study, is not available for use by consumers and is excluded from health plans.

Medical (scientific) evidence — this is the most current research available about the procedure or treatment regarding your claim that the physician reviewer will use to determine or the validity your claim.

Medical necessity — treatments, services or procedures that are justified as reasonable, necessary, or appropriate, according to the accepted or evidence-based clinical standards of care are considered to be medically necessary.

NAIC — the National Association of Insurance Commissioners is an organization of state insurance regulators, who seek to assist one another in achieving insurance regulatory goals.

NAIC Health Carrier Uniform External Review Model Act — a Model Act established by the National Association of Insurance Commissioners to provide more uniformity for external appeals. The purpose of this standard, according to NAIC, is "to provide uniform standards of the establishment and maintenance of external review processes."

NAIRO — the National Organization of Independent Review Organizations is a trade group of independent review organizations (IROs).

Second-level appeal — please see internal appeal.

Self-funded (self-insured) health plan —a health insurance arrangement in which an employer acts as the insurer and provides health or disability benefits to employees with its own funds. By doing so, the employer directly assumes the risk for payment of benefits for any claims. The United States Department of Labor, Employee Benefits Security Administration (DOL-EBSA) under the federal Employment Retirement Income Security Act (ERISA) governs most employer funded plans, which are therefore not subject to state laws and regulations. Self-funded plans are often handled by third-party administrators.

Standard of care — this is the quality of care that a "typical practitioner" would practice. Think of it as how any qualified practitioner would handle your care under similar circumstances. The purpose of this concept is to provide consistent quality of care.

Standard review — a non-emergency review of a claim, which does not jeopardize the consumer's health or life and is conducted within the time-frames established by your plan or state.

Third-level appeal — please see external review.

Third-party administrator (TPA) — an organization that processes health plan claims without carrying any insurance risk. Oftentimes, TPAs are used to manage self-funded health plans.

URAC — an independent, nonprofit, quality standard accrediting organization, URAC promotes healthcare quality through its accreditation, education and measurement programs. For example, through accreditation and benchmarking processes, it ensures that health plans, preferred provider organizations and IROs conduct business according to the established national quality standards. Currently, URAC is the only "nationally recognized accrediting body" that accredits IROs.

NAIRO
National Association of Independent Review Organizations

Resources:

- A Consumer Guide to Handling Disputes with Your Employer or Private Health Plan: http://www.kff.org/consumerguide/7350.cfm

- Affordable Care Act Implementation FAQs: http://cciio.hhs.gov/resources/factsheets/aca_implementation_faqs.html

- Approved listings of IROs by state: http://www.naic.org/state_web_map.htm

- Clinical trail information: http://clinicaltrials.gov/ct2/info/understand

- ERISA consumer information on health plans (self-funded plans): http://www.dol.gov/ebsa/consumer_info_health.html

- ERISA process: http://www.acatoday.org/pdf/erisaflowchart.pdf.

- External appeals (for self-funded plans and states without a defined external appeal process): http://cciio.hhs.gov/programs/consumer/appeals/

- General information about IROs http://www.nairo.org

- Glossary or insurance terms http://www.naic.org/consumer_glossary.htm

- Independent review organizations: http://nairo.org/payors-find.php

- National Organization of Insurance Commissioners (NAIC) http://www.naic.org

- NAIC Mode Standard http://www.dol.gov/ebsa/pdf/externalreviewmodelact.pdf

- Patient Bill of Rights: http://www.hhs.gov/ociio/regulations/patient/index.html (archive only) and http://cciio.cms.gov/programs/marketreforms/billofrights/index.html

- Patient Rights Frequently Asked Questions (FAQ): http://nairo.org/patients-faq.php

- Patients Must Know Rights When Health Plans Deny Claims: http://nairo.org/news.php

- Self-funded (self-insured) appeal process: http://www.dol.gov/ebsa/

- State Departments of Insurance: http://www.naic.org/state_web_map.htm

- U.S. Department of Health and Human Services (regarding appeals): http://www.hhs.gov/ociio/regulations/consumerappeals/

- U.S. Department of Labor Employee Benefits Security Administration (DOL-EBSA) http://www.dol.gov/ebsa/

- U.S. Department of Labor Employee Benefits Security Administration (DOL-EBSA) regional offices http://www.dol.gov/ebsa/aboutebsa/org_chart.html