



A CONSUMER'S GUIDE TO

HEALTH INSURANCE UTILIZATION REVIEW, APPEALS AND GRIEVANCES AND EXTERNAL REVIEW



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If you are a health care consumer and have a complaint about your insurer's denial of a claim or some other company action, the North Carolina Department of Insurance is ready to help you. You may not know that most health plans offered by North Carolina licensed health insurance companies must provide you with an appeal and grievance process. However, these processes might not be easy to understand. If you have questions, the North Carolina Department of Insurance has answers!

The Department can explain the appeals process and assist you with filing your appeal. If you fail to win your appeal, the Department will assist you with requesting an External Review if you meet the eligibility requirements.

This guide will explain your appeal rights as a consumer (if you are covered by a health plan that is subject to North Carolina insurance laws), and how to prepare an appeal to file with your health insurance company. If you still have questions, please call us. We can help you sort through the process of filing an appeal or grievance with your health insurance company.

In addition to the information contained in this guide, I encourage you to take the time to read the information provided by your health plan when you first enrolled (your certificate of coverage, insurance policy and member handbook). This information will contain more details about your plan's appeal and grievance procedures.

When you know your rights, getting the health care coverage you need is much easier. If you have questions, we are here to help you. You can call the Department's Health Insurance Smart NC Program at 1-855-408-1212 and an insurance specialist will help you with your medical appeal or external review request.

UTILIZATION REVIEW & NONCERTIFICATIONS

When your health insurance company receives a claim for healthcare services that you have received, or is asked to approve treatment that has not yet been provided, the insurance company will likely evaluate whether the services are medically necessary for your specific medical condition. This evaluation process is known as “utilization review” (or “UR”, for short).

Most requests and claims are considered appropriate and are paid. Sometimes, however, a company determines that the specific healthcare services or settings requested are not medically necessary. This decision is called a “noncertification” and state laws exist that address how a company must go about making these decisions.

HOW DOES STATE LAW REQUIRE MY INSURANCE COMPANY TO RUN ITS UR PROGRAM?

State law requires insurance companies to:

- Administer the UR program under the supervision of a medical doctor;
- Use sound, periodically reviewed medical review criteria;
- Obtain information about your medical condition before denying payment; and
- Use a medical doctor who is licensed in this state to evaluate the appropriateness of a denial.

HOW LONG MUST I WAIT FOR A UR DECISION FROM MY HEALTH INSURANCE COMPANY?

If you ask your company for “prior approval” before receiving a service, or if you are asking them to continue payment for services for which you have previously been approved (for example, continuation of a hospital stay, ongoing course of physical therapy, etc.) your company has three business days to notify your healthcare provider in writing if the service has been approved. If the service is “noncertified,” though, the company must also send you written notice of that decision.

If you are requesting approval for a medical service that has already been provided, the company has 30 days after they receive all the necessary information to respond with a decision.

HOW MUCH INFORMATION MUST MY HEALTH INSURANCE COMPANY PROVIDE WHEN IT ISSUES A NONCERTIFICATION DECISION?

When your health insurance company issues a noncertification, state law requires the company to provide the following information to you in writing:

- The clinical reason or rationale the company used to make the noncertification decision;
- Instructions for appealing the decision;
- Instructions for requesting the medical review criteria they used; and

Contact information and instructions on obtaining additional assistance and recourse that is available through the Department of Insurance.

WHAT IS AN APPEAL?

If you or your healthcare provider believes that the insurance company's noncertification decision is wrong, North Carolina law allows you to challenge the company's decision by filing a "first-level appeal."

Things to know about an appeal include:

- An appeal is voluntary — you can choose to appeal, or not to appeal.
- You can appeal a noncertification decision, but not a decision to deny coverage because the specific healthcare services are clearly excluded under the terms of your health insurance policy. Your policy should clearly list services that are excluded from coverage.

IS A FORMAL APPEAL MY ONLY OPTION?

Some health insurance companies have a voluntary, informal reconsideration process in addition to the formal appeal process. Your member certificate will tell you whether your plan provides such an option. The informal reconsideration process provides an opportunity for your doctor and the company's own physician to discuss your medical condition in detail and, if possible, resolve the matter without a formal appeal. Your plan cannot require you to participate in this informal process, but it may help you resolve the matter in less time and with less effort.

HOW DO I PURSUE A FORMAL APPEAL?

To begin the appeal process, you or your healthcare provider must submit a written, first-level member appeal to the insurance company. If your healthcare provider submits the appeal on your behalf, be sure to have him or her include your signed authorization allowing him or her to do so, along with a clear indication that a member appeal is being requested on your behalf. Instructions for filing an appeal will be included in the written noncertification notice that the insurance company sent to you and your provider. Your member certificate should also provide you with instructions. The appeal should include a clear explanation of why you believe the company's noncertification was wrong, and (if appropriate) additional documentation to support your position. Be certain to make this request within the deadline specified in the noncertification notice.

Within three business days after receiving your first-level appeal, the insurance company must tell you the name of your appeal coordinator and how to contact him or her. It must also provide instructions on how to submit written statements or materials to be included with the appeal. Your appeal must be evaluated by a medical doctor licensed in North Carolina who was not involved in the original noncertification decision.

Within 30 days after receiving your appeal, the insurance company must send you and your provider its decision in writing. This written notice must include:

- The qualifications of persons involved in reviewing your appeal;
- A statement of the reviewer's understanding of the reason for your appeal;
- The plan's decision and medical rationale, with enough detail for you to respond to that decision if needed;
- The evidence or criteria that on which the decision was based, and instructions on how to obtain those criteria;
- Instructions for submitting a "second-level grievance" (see section on Grievances, below); and
- Contact information for the Department of Insurance, to obtain assistance and information on other recourses available.

WHAT IF MY CONDITION IS SERIOUS AND I CAN'T DELAY MY HEALTHCARE SERVICES FOR 30 DAYS, WHILE I WAIT FOR AN APPEAL DECISION?

If the amount of time required to wait for your insurance company's appeal decision would appear to seriously jeopardize your life, health or ability to gain maximum function, you or your healthcare provider can request an "expedited first-level appeal." The company:

- May request medical documentation proving that you need an expedited review;
- Must communicate its decision in writing to you and your healthcare provider within four days after receiving the information proving that an expedited review is necessary.

If your medical condition is urgent and four days is still too long to wait, you may be eligible for an expedited External Review through the North Carolina Department of Insurance's External Review Program. You must first request an expedited appeal with your health plan. Your External Review request will be reviewed for eligibility and then evaluated by a medical professional to determine if the time frame required to complete an expedited appeal with the health plan would reasonably jeopardize your life, health or ability to regain maximum function. If you are not eligible, you would need to complete the health plan's appeal process.

You may not request an expedited first-level appeal for services that have already been provided. Such an appeal must go through the standard appeal time frames.

WHAT IF I'M STILL NOT SATISFIED WITH THE PLAN'S FIRST-LEVEL APPEAL DECISION?

If you are not satisfied with the insurance company's first-level appeal decision, you can then request a "second-level grievance" (see section on Grievances).

WHAT IS A GRIEVANCE

A first-level grievance is different than a first-level appeal, because it does not involve a medical necessity (noncertification) decision. A first-level grievance can relate to any other insurance company decision, policy or action that affected you. Examples include the availability, delivery or quality of health care services; claims payment or handling; reimbursement for services; or the contractual relationship between you and the insurance company.

HOW DO I FILE A FIRST-LEVEL GRIEVANCE WITH MY INSURANCE COMPANY?

You (or your provider acting on your behalf) can request a first-level grievance by submitting your complaint in writing to the insurance company. The instructions on how to file a grievance must be included in your member certificate. The grievance process is voluntary.

WHAT HAPPENS NEXT?

Some insurance companies have an informal review process designed to resolve grievances quickly. If your company does not have such a process or if your grievance is not resolved as a result of the informal process, you are first entitled to a formal, first-level grievance.

Within three business days of receiving your written request for a first-level grievance, the company must provide you with contact information for your grievance coordinator and tell you how to submit written material for consideration by the grievance review panel.

WHO REVIEWS MY COMPLAINT?

Only personnel who have not already been involved in the matter may review your grievance. If your complaint involves a clinical matter, at least one of the panel members must be a medical doctor with clinical expertise appropriate to the matter under consideration.

WHEN CAN I EXPECT A RESPONSE FROM MY HEALTH PLAN?

The insurance company must issue a written decision within 30 days after receiving your grievance. In its decision, the company must:

- Inform you of the professional qualifications of the reviewers;
- Provide a statement of the reviewers' understanding of your complaint;
- Clearly state the reviewer's decision, including any contractual or medical basis for the decision in enough detail that, if needed, you could further respond to the decision;
- Describe the evidence used as the basis in making the decision; and
- Advise you of your right to a "second-level grievance review" and instructions on how to make this request.

If your grievance involves issues relating to the quality of care that you received from a healthcare provider, the insurance company will acknowledge your grievance within 10 business days. The notice must advise you that your concern will be referred to the quality assurance committee for review and consideration or any appropriate action against the provider.

I'VE COMPLETED THE FIRST-LEVEL GRIEVANCE WITH MY INSURANCE COMPANY AND I'M NOT SATISFIED. WHAT NOW?

If you have completed either:

- a first-level appeal of a UR noncertification decision, or
- a first-level grievance of your insurance company's other action or decision

If you are not satisfied with the insurance company's decision, you can request a "second-level grievance." This is the next voluntary step for both first level appeals and first level grievances.

A second level grievance requires the insurance company to form a review panel and conduct a hearing, which you are entitled to attend, whether in-person or by phone.

HOW DO I PURSUE A SECOND-LEVEL GRIEVANCE REVIEW?

You (or your provider acting with your written consent) may request, in writing, a second-level grievance review. This request must be submitted to the insurance company within the timeframes outlined on the first level denial letter. Within 10 business days after receiving your request, the company must assign a hearing coordinator and tell you how to contact him or her. You have the right to:

- Request information relevant to your case from your plan;
- Attend the hearing and present information to the review panel;
- Submit supporting materials before and at the review hearing;
- Ask questions of panel members; and
- Be assisted or represented at the hearing by a person of your choosing, including an attorney.

Although you are not required to attend the hearing, doing so will allow you to present your case directly to the panel members and ask them questions. Unless you have an attorney present, the insurance company cannot be represented at the hearing by its own attorney.

The insurance company must hold your review hearing within 45 days after receiving your request for a second-level review. The company must notify you of the hearing date, time and location, at least 15 days in advance.

WHO CAN SERVE ON THE PANEL HEARING MY GRIEVANCE?

The second-level grievance panel must be comprised of persons who were not previously involved in any matter giving rise to your grievance, who are not employees of your health insurance company and who do not have any financial interest in the outcome of the review. If the matter under review is clinical in nature, the panel must consist of medical practitioners with appropriate expertise, including at least one medical provider who has the same or similar specialty as your own provider, and who routinely provides the healthcare service that is being reviewed.

HOW LONG WILL I WAIT FOR A DECISION?

The insurance company must issue a written decision within seven business days after the hearing. The written decision must include:

- The qualifications of review panel members;
- A statement of the panel's understanding of the nature of your complaint;
- The panel's recommendation to the plan;
- The rationale behind the panel's recommendation;
- A description of the documentation considered by the panel;
- A clear statement of the final decision; and
- Contact information and instructions on how to request an External Review from the Department of Insurance if a noncertification denial remains upheld.

If the final decision differs from the panel's recommendation, the rationale for the decision must also be provided.

IS AN EXPEDITED SECOND-LEVEL REVIEW AVAILABLE?

If the time required to receive the insurance company's second-level grievance decision reasonably appears to seriously jeopardize your life or health, or your ability to regain maximum function, you or your healthcare provider can request an "expedited second-level grievance" even if the review at first-level was not expedited. In the interest of time, the expedited second-level review may take place via conference call or by the exchange of written information.

The company

- May request medical documentation proving that you need an expedited review;
- Must communicate its decision in writing to you and your healthcare provider within four days after receiving the information proving that an expedited review is necessary.

The company must conduct the hearing and communicate its decision within four days after reviewing all necessary information. If you have already received the services in question, expedited review is not available.

WHAT IS AN EXTERNAL REVIEW



The North Carolina Department of Insurance administers a free service called External Review. External Review involves an independent medical review of a health plan noncertification, and offers another option for resolving coverage disputes between you and your insurer. In North Carolina, external review is available when an insurer denies coverage for services on the grounds that they are not medically necessary (a noncertification decision), or that they are cosmetic or experimental for your specific medical condition.

For your request to be accepted for external review, you must meet eligibility requirements. A request is made directly to the Health Insurance Smart N.C. Division and each case is reviewed for completeness and eligibility. If accepted for external review, the case is assigned to an independent review organization (IRO) for a clinical review and final decision.

IF YOU HAVE QUESTIONS, THE HEALTH INSURANCE SMART N.C. DIVISION OF THE DEPARTMENT OF INSURANCE IS HERE TO HELP.

Toll free: 855-408-1212

www.ncdoi.com/smart

Fax: 919-807-6865

North Carolina Department of Insurance
1201 Mail Service Center
Raleigh, NC 27699-1201

You can find additional information as well as a downloadable copy of our [Request for Assistance](#) and [External Review](#) form on the NCDI Web site.

NC Department of Insurance | Mike Causey, Commissioner | www.ncdoi.com